16651/SAB/PJB Attorney ID# 6224469

**IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF ILLINOIS -
EASTERN DIVISION**

KRISHNA NARSIMHAN Plaintiff, vs. LOWE'S HOME CENTERS, LLC, Defendant.	))))))))	Case No.: 1:19-cv-01255

PLAINTIFF'S MOTION IN LIMINE # 16

TO BAR THE OPINION TESTIMONY OF JOSHUA PRAGER, M.D. RELATING TO PLAINTIFF'S STATE OF MIND AND LEVELS OF PAIN BASED ON RECORDS FROM WHEATON CHIROPRACTIC

NOW COMES Plaintiff, KRISHNA NARSIMHAN, by and through his attorneys, ANESI, OZMON, RODIN, NOVAK & KOHEN, LTD., prior to the selection of the jury in this cause, moves this Honorable Court to enter an Order *in Limine* barring and prohibiting Defendant, LOWE'S HOME CENTERS, LLC, or its counsel, agents, employees and/or any witness called by the Defendant, or questions by defense counsel from making statements, offering evidence, testimony , remarks, arguments or from conveying directly or indirectly to the panel by any means, including the fact that this motions have been presented and ruled upon, for the subject matter identified in the title and body of this motion, and in support states as follows:

INTRODUCTION

Plaintiff seeks an order from the Court barring any testimony of defendant's medical witness, Joshua Prager, MD, regarding the Plaintiff's state of mind and/or the

severity of Plaintiff's subjective complaints of pain in his lower right extremity, based on records from Wheaton Chiropractic. Plaintiff argues this testimony is speculative, irrelevant, unfairly prejudicial since it is unreliable and Defendant cannot meet its evidentiary burden under Federal Rule of Evidence 702.

RELEVANT FACTS

Plaintiff was injured on June 25, 2016 at Lowe's Home Center in Carol Stream wherein one of Defendant's employees caused a metal down rod to strike Plaintiff's right lower extremity. Shortly thereafter the occurrence Plaintiff sought medical treatment for pain in right lower right extremity suffered as a result, including; Northwestern Memorial Convenient Care Center (urgent care), Northwest Neurology (neurologist), SportMed Wheaton *Orthopedic* (orthopedist), Saint Anthony Hospital (2 MRIs) as well as following up with his primary care physical Dr. Sunil N. Matiwala (internist) at Center for Adult Healthcare, SC.

While under the care of these medical providers, Plaintiff visited chiropractor, Scott Hallums, D.C. at Wheaton *Chiropractic*, for chiropractic treatment for an unrelated complaint of left neck pain with radiation into the left wrist with numbness and tingling. At that first visit, as well as subsequent visits, Plaintiff explained the symptoms he was experiencing related to his neck and upper extremities only. Dr. Hallums' chart does not reflect any discussions of other body parts for which he was not treating the Plaintiff.

Defendant's medical witness, Dr. Joshua Prager opines, that regardless of the other treatment Plaintiff received or was receiving at the time of the chiropractic treatment, and regardless of whether Dr. Hallums was treating a completely separate body part, the lack of any notation of right, lower extremity pain is evidence that Plaintiff

was not experiencing pain to that part of his body or was not experiencing pain sufficient to be associated with CRPS because if he had, Plaintiff would have told Dr. Hallums and it would be reflected in the chiropractic records.

ARGUMENT

Relevant evidence is evidence that has "any tendency to make the existence of any fact that is of consequence to the determination of the action more probable or less probable than it would be without the evidence." *Fed.R.Evid. 401* Relevant evidence is excludable under Federal Rule of Evidence 403, on the basis that its probative value is outweighed by the danger that it will cause unfair prejudice, confuse the issues, mislead the jury, cause undue delay, waste time, or be needlessly cumulative. *Fed. R. Evid. 403.* Dr. Prager is offering evidence of another doctor's state of mind that is irrelevant and prejudicial since he has no basis for such an opinion.

The admissibility of expert witness testimony is governed by Rule 702 of the Federal Rules of Evidence and the body of case law that has developed from the Supreme Court's decision in *Daubert v. Merrell Dow Pharmaceuticals, Inc.*, 509 U.S. 579, 113 S. Ct. 2786, 125 L. Ed. 2d 469 (1993). Under Rule 702, expert testimony is admissible if "scientific, technical, or other specialized knowledge will assist the trier of fact to understand the evidence or to determine a fact in issue." Fed. R. Evid. 702. Rule 702 also "requires that (1) the testimony must be based upon sufficient facts or data; (2) it must be the product of reliable principles and methods; and (3) the witness must have applied the principles and methods reliably to the facts of the case." *Happel v. Walmart Stores, Inc.*, 602 F.3d 820, 824 (7th Cir. 2010)(citing Fed. R. Evid. 702). This rule

"applies to all expert testimony, not just testimony based on science." *Durkin v. Equifax Check Servs., Inc.*, 406 F.3d 410, 420 n.10 (7th Cir. 2005).

Rule 702 requires that the district court act as a "'gatekeeper' who determines whether proffered expert testimony is reliable and relevant before accepting a witness as an expert." *Autotech Tech. Ltd. P'ship v. Automationdirect.com*, 471 F.3d 745, 749 (7th Cir. 2006). In exercising its gatekeeper function, a district court must examine (among other things): (1) the expert's qualifications; (2) the expert's methodologies; and (3) the relevance of the expert's proposed testimony. *Adams v. Ameritech Servs.*, 231 F.3d 414, 423 (7th Cir. 2000).

Courts are expected to reject any subjective belief or speculation by an expert. *Ammons v. Amamark Unif. Servs., Inc.* 368 F.3d 809, 816 (7th Cir. 2004).

A. Any Testimony By Dr. Prager Opining or Inferring Plaintiff's State of Mind or Severity of Pain is Speculation and Should Be Barred.

Any testimony by Dr. Prager as to Plaintiff's state of mind while under the care of Dr. Hallums is pure speculation. Furthermore, any attempt to use the records characterize or categorize Plaintiff's pain is speculation and not based on any scientific, technical or specialized knowledge. Dr. Prager offered the following testimony at his deposition as to why Plaintiff did not record or report pain to his right, lower extremity to Dr. Hallums:

(Exhibit A: Deposition of Joshua Prager, MD, Vol. 1, Pg. 152, lines 6-19 taken June 21, 2021)

> *A. Because, as I pointed out to Mr. Berman, if there was active CRPS between 2016 and 2018, the person active in the medical system would have complained about what he complained about, and then the Wheaton Chiropractic records where he himself filled out a form where he indicated hand pain but didn't indicate foot pain or leg pain is more evidence that nothing was bothering -- that*

the foot was not a CRPS kind of foot or leg or not CRPS issues at that time and during the succeeding three months where there was never any mention of the foot or the leg as sufficient information to indicate that between 2016 and 2018 that there was no CRPS whether or not we hypothetically accept that there was a diagnosis.

(Exhibit B: Deposition of Joshua Prager, MD, Vol. 2, pg. 189:05-190:01 taken October 7,2021)

Q. I know. And I'm asking you if you're making an assumption that not only did Mr. Narsimhan not express that he had right lower extremity pain during his chiropractic care at Wheaton Chiropractic, but is it your opinion that he did not have any right lower extremity pain during that September to December time frame he was being treated by the chiropractor over at Wheaton Chiropractic?

A. I would -- I -- I -- yes, that would be my opinion.

Q. Okay. Isn't that then making an assumption about a fact that's actually not in the record?

A. Well, one -- one does an evaluation at the beginning and then takes a history. What is or is not in that history is what is the legal document. And I'm not the lawyer, but my understanding of medical records is that if it's not there -- if it's not documented, it's not there.

(Exhibit B: pg. 191:17- pg. 192:09)

Q. Okay. So you're making a judgment about Mr. Narsimhan saying that he would have put down right lower extremity pain on the forms, and he would have complained about that to the chiropractor when he's going to see the chiropractor for his neck and forearm and wrists. And since he didn't do that, that means that Mr. Narsimhan wasn't having any pain in his right lower extremity, right?

A. No. He wasn't having enough to be putting it down there. And, you know, again, we're only looking at a microcosm of -- of this case. And there are a lot -- there's a lot of other relevant information that was discussed in the first part of this deposition that we're not going to discuss today that contributes to my opinions, such as the videos of him.

(Exhibit B: pg. 192: 22- pg. 193:24)

Q. I thought you were saying that it is your opinion that during the time Mr. Narsimhan was going to Wheaton Chiropractic for chiropractor care for his neck, forearms, and wrists that he was, in fact, not having right lower extremity pain or discomfort because it's simply not written down or wasn't reported to the chiropractor.

MS. HAY: I'll just object to as mischaracterizing his prior testimony. But you can go ahead and answer, Doctor.

A. Well, I think there may – what you heard and what you inferred and what I implied I think are two very different things. And so maybe I should just be more emphatic and ask Margie to strike or to -- for the sake of clarity, I'll just say and -- that we should disregard what was previously stated, because it could seem somewhat convoluted, and state more clearly this is my opinion, disregarding the other part.

Is that the fact that Mr. Narsimhan did not document any pain in his leg on the forms and in the history -- oral history that he provided is an indication to me that his leg was not troubling him at that time.

(Exhibit B: pg.194:12 – pg. 196:06)

Q. I'm trying to follow up and understand what you mean when you say not troubling him.

A. Okay. That he was not having significant pain enough to write it down --

Q. Okay.

A. -- or report it.

Q. Well, that does help answer my prior questions. And so I guess I just want to make sure we're clear, and just to follow up again one more time. Is -- what you're saying is during the time that Mr. Narsimhan was seeing the chiropractor over at Wheaton Chiropractic, he may have had some pain or discomfort in his right lower extremity, but just not significant enough at that time to be reportable -- or for him to report it. Is that what you're saying?

A. I think you're restating, kind of massaging what I said a little bit, that there was no pain of significant consequence to be able to -- for him to feel it was important enough to report it.

Q. Yeah. But what that means is he may have had some pain or discomfort, but just not to the level of significance enough to report. Am I right? Is that accurate?

A. Well, you know, if we -- I will accept that with the following caveat that CRPS pain would not fit into that category.

Q. But would you actually answer my question though?

A. Well, that is your --

Q. No.

A. The answer. I think I am answering your question.

Q. I didn't ask about CRPS.

A. I'm saying that if it -- that, perhaps, if I accept your hypothesis that there was some pain, but not enough to report, my opinion is that if that was true, and it could possibly be true, it would only be true if it wasn't the pain of CRPS because that pain would not be characterized by the way that you are characterizing it.

However, Dr. Prager later testifies the pain is simply not documented by Plaintiff or Dr. Hallums but that any inquiry as to why should be answered by the Plaintiff:

(Exhibit B: pg. 173:13 – 23)

Q. The fact that some aspect of his pain or discomfort is not written down in that confidential page -- confidential health report, if it's not written down, it doesn't mean that he doesn't necessarily have pain.

A. It means he's not documenting it.

Q. It means he's not documenting, exactly. And why he's not documenting, we'd have to ask him, not you. Would you agree?

A. I would agree.

At most, Dr. Prager could only testify there is no mention of the right lower extremity in the records. He would be unable to give any reason or speculate why that would be.

B. Any Testimony Regarding Plaintiff's Chiropractic Treatment Is Irrelevant to Any Issue In This Case and Should Be Barred.

Secondly, any testimony relating to treatment received from Dr. Hallums for neck and upper extremity symptoms is irrelevant to the injuries claimed by the Plaintiff. Plaintiff is not claiming he injured his neck or upper extremities in the occurrence nor is he seeking damages for his chiropractic treatment with Dr. Hallums. Dr. Prager does not give any testimony that the symptoms in the neck and upper extremities are the cause of the right lower extremity symptoms, nor does he opine that the treatment provided by Dr. Hallums was in any way connected with the lower extremity. Dr. Prager only testifies that he thinks a chiropractor would want to know about this:

(Exhibit B: pg. 170:7-20)

Q. Do you have an opinion as to whether Narsimhan's right lower extremity injury would be relevant to the chiropractor in his care and treatment of the neck, forearm, and wrist issues?

A. Well, the way you're wording the question, the care of the -- the leg would not necessarily be relevant to what he was doing, but the knowledge of it existing would be relevant.

Q. Why?

A. Because you need to know everything that's going on in a patient when you're treating them.

(Exhibit B: pg. 185:24-188:10)

Q. In this case there's a lack of information in the Wheaton Chiropractic records documenting any, one way or the other, any information about the right lower extremity; would you agree?

A. There is no information with regard to the -- to the lower extremities.

Q. And so the Wheaton -- so when you say no information, what -- what I'm asking you, to be clear, is in the Wheaton Chiropractic records, there's no information about the right lower extremity one way or the other, injured, not injured, pain, not pain, it doesn't even mention it?

A. Well, actually, that's not necessarily true, because the absence of positive information is negative information. And the failure to document is basically a statement that there is nothing going on there. Now, you don't have to go along stating a bunch of negative things. But if things are positive, they need to be stated; and if they're not, it's assumed they're negative.

Q. So I'm just wondering how -- how extensive that -- that opinion is. If a patient, such as Mr. Narsimhan, would go to a cardiologist to get tested, but doesn't mention anything about his right lower extremity pain or symptoms, does that mean that he's not having that pain on that day that he sees his cardiologist?

MS. HAY: I'm going to object as an incomplete hypothetical based on facts not in evidence as well as form. But I think you've answered that.

MR. BERMAN: And there's no objection such as that in the rule of evidence. But go ahead and answer it. Please, answer.

THE WITNESS: If you're going to a cardiologist with a serious heart problem, you're probably not going to be talking about what's going on in your leg because that's a life-threatening situation. When you're going to a chiropractor and it's all about pain, and they're doing a spinal examination and they have a history form that specifically requests

information regarding all body parts that could be having pain and you leave it out, that's a negative.

Q. It sounds to me, Doctor, when you say the absence of positive information is the negative information, what you're saying is that, because in the Wheaton Chiropractic records the right lower extremity isn't mentioned one way or the other, that therefore means that during those office visits and during that time frame that Mr. Narsimhan was seeing a chiropractor, he was not having any pain in his right lower extremity. Is that what you're saying?

A. There is no documented pain in his lower extremity.

Q. Okay.

A. And that would be relevant to a chiropractor.

Dr. Prager's testimony assumes that he knows what is relevant for a chiropractor treating a patient even though he has never worked as one (*Ex. B, pg. 166:23-167:10*) or hold himself out as an expert in the field. (Ex. B, pg. 168:9-12) He also assumes what is important to Dr. Hallums relating to the chiropractic treatment of the Plaintiff as it relates to the neck and upper extremities. However Dr. Hallums testified as to what was relevant to him while treating the Plaintiff:

(Exhibit C: Deposition of Scott Hallums, DC, pgs. 52:20-55:07, taken November 11, 2021)

Q. Okay. The fact that Mr. Narsimhan didn't tell you that he was seeing a neurologist for right lower extremity pain during the time he was seeing you 2016, doesn't mean it didn't exist or that treatment didn't happen, do you agree?

A. I would agree.

Q. Okay. The fact that Mr. Narsimhan didn't talk to you, the doctor who was treating him for neck and upper extremity issues, about his right lower extremity problem that he was seeing another doctor for doesn't mean the right lower extremity problems didn't exist. Would you agree?

A. I would agree.

Q. And as a chiropractor, you don't treat every patient's whole body; is that true?

A. That is true.

Q. As a chiropractor, sometimes patients come in, they have a particular pain that they want to be treated, whether it be the neck, arms, back, low back, upper back, or the hips or anything, the focus on that pain or that problem that the patient comes in for; right?

A. That is correct.

Q. In fact, I think you said early in today's deposition, patients when they come to see you, you do a thorough assessment of what they presented with; right?

A. That is correct.

Q. And that's from your review of your records, that's what you did with Mr. Narsimhan. He comes and presents with a neck and upper extremity issue and you do a thorough assessment of that; right?

A. Correct.

Q. You weren't focusing on his ankle or feet or his hips; you were focusing on what he came in and presented with; right?

A. Correct.

Q. You had asked about your general examination of gait and moving around the office, and there is nothing particularly noted as problems with that; right

A. Correct.

Q. Okay. And you didn't notate, though, any indication that he was having pain when he turned his head or moved his head; you didn't put any notes on that even though that's what he's coming in for, neck or upper extremity; right?

MS. FOWLER: I'll object. I think he did note that, Steve. It's in his records.

THE WITNESS: I think I did, but I will -- let me -- right here. Yes. I did note that on his neck with extension he had pain and tenderness, with left lateral bending he had tenderness, with right lateral bending he had pain and tenderness.

Q. (By Mr. Berman) Perfect. That's exactly what you were focusing on during this examination; right?

A. Correct.

Q. So the whole point of this examination really is to focus on his neck and back and upper extremities; right?

A. It was to focus on what he presented to the office with his chief complaint, yes.

Whether Plaintiff did or did not discuss the right, lower extremity with Dr. Hallums was not relevant to Dr. Hallums and the focus was solely on the neck and upper extremities.

C. Defendant Cannot Meet Its Burden to Show Dr. Prager's Opinions Based on the Chiropractic Record Satisfy Federal Rule of Evidence 702.

Any probative value this proposed opinion testify by Dr. Prager is substantially outweighed by danger of unfair prejudice, confusion of the issues, and would mislead the jury. But moreover, this testimony does not satisfy Federal Rule of Evidence 702. The testimony discussed above is unreliable because the opinions are simply speculation and conjecture by Dr. Prager. These opinions are not based on scientific, technical, or other specialized knowledge that would assist the jury to understand the evidence or to determine a fact in issue. Dr. Prager's opinions are not the product of any reliable principles and methods, nor could Dr. Prager apply such when he is simply extrapolating a meaning from the absence of reported symptoms in Plaintiff's chiropractic records. However, in forming his opinions about Plaintiff's pain, Dr. Prager ignores or does not consider that Plaintiff was concurrently seeing other providers for CRPS and he was actively under a doctor's care and taking medication for the pain that was later diagnosed to be associated with CRPS. The failure to take this into account show the opinion is not based on all the facts and thus unreliable.

CONCLUSION

WHEREFORE, Plaintiff respectfully requests this Court enter an order barring and prohibiting Defendant, LOWE'S HOME CENTERS, LLC, or its counsel, agents,

employees and/or any witness called by the Defendant, or questions by defense counsel from making statements, offering evidence, testimony, remarks, arguments or from conveying directly or indirectly to the panel by any means, including the fact that this motions have been presented and ruled upon, as to Dr. Prager's testimony or opinions based on the Wheaton Chiropractic records, including:

- Any testimony attempt to explain why right, lower extremity pain is not noted in the chiropractic records;
- Plaintiff's state of mind when treating with Dr. Hallums and what was important;
- Whether Plaintiff was experiencing any right lower extremity pain when under the care of Dr. Hallums;
- Any attempt to characterize or categorize the severity of Plaintiff's pain based on the chiropractic records;
- Any testimony that information about the right, lower extremity would have been relevant to Dr. Hallums;
- Any opinions regarding the standard of care for a chiropractor when Plaintiff was under Dr. Hallum's care.

Respectfully submitted:

/s/Steven A. Berman

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IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF ILLINOIS
EASTERN DIVISION

KRISHNA NARSIMHAN,)
)
Plaintiff,)
)
-vs-) Case No. 1:19-cv-01255
)
LOWE'S HOME CENTERS, LLC,)
)
Defendant.)
)
_____)

The deposition of JOSHUA P. PRAGER, M.D., called for examination pursuant to the Rules of Civil Procedure for the United States District Courts pertaining to the taking of depositions, taken before Judith T. Lepore, Certified Shorthand Reporter for the State of Illinois, License No. 084-004040, via videoconference, at the hour of 3:03 p.m.

ALL APPEARANCES VIA VIDEOCONFERENCE:

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EXHIBITS

THE REPORTER: On the record. This deposition is being taken by means of Zoom video teleconference. The attorneys participating in this deposition acknowledge that I am not physically present in the deposition, and the oath will be administered remotely.

The parties and their counsel consent to this arrangement and waive any objections to this manner of reporting.

Will all counsel present please state your name and indicate your agreement on the record.

MR. BERMAN: Steve Berman. I agree.

MS. HAY: Linda Hay for the defendant. Agreed.

(Witness duly sworn.)

MR. BERMAN: Doctor, will you please state and spell your full name.

THE WITNESS: Joshua P. Prager, M.D., M.S., D.A.B.P.M.

MR. BERMAN: Is it P-r-a-g-e-r your last name?

THE WITNESS: Correct.

MR. BERMAN: Thank you.

For the record this is the deposition of

EXHIBIT
A

Dr. Joshua Prager taken pursuant to notice and taken pursuant to the applicable Federal Rules of Civil Procedure.

JOSHUA P. PRAGER, M.D.,

called as a witness herein, having been first duly sworn, was examined and testified as follows:

EXAMINATION

BY MR. BERMAN:

Q. Dr. Prager, I'm assuming you've given depositions before, right?

A. I have. I'm just trying to clean up -- because I'm having a little trouble hearing you. So I'm trying to clean up some background noise here, and I think I already did.

Okay, I have. And if you're going to ask me about the admonitions, I'm happy to dispense with all admonitions or no admonitions, but I prefer not to have some --

Q. I'm happy to dispense with all of them. Except for one thing I would to say everybody -- for the record at least I say is, if there's ever a question I ask you that's not clear in any way or not understandably phrased, don't answer and ask me to

rephrase it. If you answer the question, I will assume you understood the question the way it is was phrased, okay?

A. Fair.

Q. Let's go through some brief background information.

What is your -- what's your date of birth?

A. [redacted]/49.

Q. What's your residence address?

A. [redacted], Santa Monica, California.

Q. And what is your profession?

A. I am a licensed medical doctor.

Q. What is the name of your practice or where you practice?

A. Well, it's Joshua Prager, M.D. is one; California Pain Medicine Centers is two; and Center for the Rehabilitation of Pain Syndromes (CRPS) is 3.

Q. Do you have a particular office or address of an office, or do you practice out of multiple locations?

A. I practice out of one office.

Q. What's the address of your office you practice out of?

A. 2001 Santa Monica Boulevard, Suite 1280 West, Santa Monica, California.

Q. And you're here today because you've been disclosed as a retained medical expert on behalf of the defendant Lowe's in this Narsimhan versus Lowe's litigation, correct?

A. That is correct.

Q. And you performed work as a medicolegal expert on other cases as well, not just this one, correct?

A. Correct.

Q. In this case you reviewed certain records; you performed an examination of Mr. Narsimhan; and you've come to certain opinions and conclusions; is that fair?

A. That is correct.

Q. And as sort of a beginning stage or beginning point, I kind of want to make sure about what you've reviewed, start there. But before I even do that, I'm going to -- I have literally two exhibits in this deposition, Doctor. I'll show you what's been marked as Exhibit A, what we're marking as Exhibit A. And all Exhibit A is is the notice of deposition that has the rider to it, and I'll just show you.

(Whereupon, Exhibit A was marked for identification.)

BY MR. BERMAN:

Q. So can you see my screen, Doctor?

A. I can.

Q. So Exhibit A is just a notice of virtual deposition with a rider it says for June 21st, 3 o'clock Central Time, and then the rider is attached to it. Have you seen this document?

A. I have not.

Q. Have you produced to the defense any documents in conjunction with this rider?

A. No, it doesn't look like I have, but I have some of them at my disposal.

Q. Well, let's just talk about that for a moment.

Per the rider for Exhibit No. 1 is your CV. I have a copy of your CV that's marked in Deposition Exhibit No. 2, which is going to be the disclosure of yourself which contains your reports and your CV and your testimony list. So we can dispense with No. 1.

No. 2 asks for any and all publications and presentations authored or prepared by you that form the basis for or support any of your opinions in this

case. Do you have those with you today?
A. I'm just trying to think if they -- just because I gave a presentation I wouldn't be using it to support, and the same for publications. So although I've published -- well, I don't know that the publications and even -- well, the publications that I have written about CRPS do not relate to this case, per se. And the presentations that I give, I don't actually have access to. So, I mean, the basis for my opinion is literature that I have read, which is not requested here explicitly, and also experience of caring for these kind of patients for better than 25 years.
Q. Okay. So at least it looks like the rider item No. 2, there would be no document that would comply with that because there's no particular publications or presentations that you've prepared or authored that relate specifically to this Narsimhan case?
A. Specifically, correct.
Q. Let's move on to three. All deposition transcripts, literature, articles, textbooks, other documents, or things you reviewed in conjunction with this case, and do you have those in front of you,

those items?
A. Yes.
Q. We can go over what those items are. I'm not going to ask you to list them right now. I'll do that in a moment, so I will dispense with that one.
No. 4 asks for notes, preliminary impressions, opinions, reports, letters, or other documents generated by you in conjunction with this case. We know you prepared at least two reports; one relating to the medical examination itself, and one that was attached to the 26(a) disclosure. What I'm wondering is, do you have any notes or handwritten notes or preliminary impressions or thoughts written down other than those reports?
A. I do not.
Q. Do you have any kind of -- going back to No. 3 where it talks about deposition transcripts or documents reviewed by you, do you have medical records that have handwritten notes on them or Post-it notes that include some of your thoughts while you were reviewing those?
A. I reviewed everything electronically, and I didn't create any electronic notes.
Q. So for No. 4 there would be nothing to

respond to, right?
A. Correct.
Q. No. 5 says, "Copies and citations of any articles, texts, literature, rules, regulations, or other materials upon which you rely to support your opinions in this case." Are there any articles or texts or literature that you rely on to support your opinions in this case?
A. There would be I would say essentially one article that has particular relevance, which is Harden's article on the diagnosis -- the diagnostic criteria for complex regional pain syndrome; otherwise known as the Budapest criteria.
Q. Dr. Harden's article, when was that from?
A. I believe around '03, but I don't know for sure.
Q. Are there any other literature, articles, texts that you think would be supportive of your opinions in this particular case?
A. Well, you know, actually, I haven't explored with anyone or written about anyone about treatment for CRPS, but I could rely on either treatment guidelines or a particular article regarding treatment algorithm for CRPS. I hadn't thought about that until

you're asking me now. But I certainly know what are in both of those, and either one could suffice to discuss treatment.
Q. Do you have a name or a citation of a particular article in mind that you're referring to right now?
A. There was one originally by Boas, B-o-a-s, and then a modification or just an update on that was written by Stanton-Hicks regarding treatment for CRPS.
Q. What year or years were those articles?
A. They are relatively old. I think Boas was around '98, and Stanton-Hicks was around 2000.
Q. Do you have the citations for any of those articles that you just --
A. I don't. It's just that I've read them, and I know them.
Q. And obviously the reason I'm asking you this question in the deposition today is because I put this in the rider asking for this information that would be relevant for me to potentially question you about during today's deposition. So you haven't produced those to defense counsel who retained you in this case, have you?
A. If we want to take just a brief pause, I

could probably find them on the internet really quickly and send them to defense counsel who could then send them to you. I don't think it would take more than five minutes. Because I haven't done that, I would deduct the time it takes me to do that from time you're paying for and also suspend the time of the deposition if necessary.

Q. I appreciate that, and we can do that when we're off the record. So I appreciate that.

Just to follow up on this one for No. 5 here, are there any articles, texts, or literature say that were written or produced in the last five years that you think are particularly relevant to CRPS or your opinions in this case?

A. No.

Q. Have you written any articles regarding CRPS in the last five years?

A. I think only in relation to the use of ketamine.

Q. The next one is No. 6. It talks about correspondence between yourself and defense attorneys or anyone on defendant's behalf. Was there any correspondence between yourself and any attorneys who retained you in this case?

A. Nothing besides letters of transmittal.

Q. So there are letters of transmittal?

A. Right.

Q. And you would be able to produce those to me as well?

A. I think so. I mean, I don't think if -- if you have my file, you will see what has been transmitted to me. So it will just say we sent you this, and you'll have this. So there's nothing other than that.

Q. The only reason, Doctor, I'm asking you is I don't have your whole file in front of me. I did the rider asking for this information, which I wasn't given any information. I thought you would produce that before today's deposition, but it wasn't. So I'm asking you about it as we're sitting here. So that's the reason.

MS. HAY: Steve, I know that the doctor has an electronic file that he has available, and I note on your rider, you know, the request is for him to produce the materials at the time of or prior to the start of this deposition. So he does have an electronic file in front of him that should contain everything, and we're happy to get a copy of that.

But he has that there and available.

MR. BERMAN: That's what I'm asking for. I didn't get it at the time of or the start of the deposition. So now we're in the middle of the deposition. We're actually inside the deposition, and I'm asking about those details because I haven't been given that before the deposition.

THE WITNESS: I can have somebody create -- while I'm doing it so it doesn't take from our time to upload everything that we have, or at least a list of it, which probably would be more efficient because everything on the list you have. So if you want me to, I'll ask my assistant to just send that list to you.

BY MR. BERMAN:

Q. You know what, in all honesty, I'm not concerned really about you duplicating depositions that you haven't notated or highlighted because I have that stuff or medical records. But if there's handwritten notes or highlights on there, I'd like to see that. If there's letters, if there is, for example, correspondence, I'd like to see that. Invoices, I'd like to see those. Just your entire file relative to this cause of action, I'd like to see

that.

A. Let's see. I lost the screen you were sharing.

Q. I'm not sharing it anymore. I'm not sharing the screen because I think the only answer to this question is, you're going to produce your entire file including all the stuff we just talked about in the rider and send it over to defense counsel.

A. With the exception of my income taxes, which I think is an invasion of privacy, and I will not send them.

Q. I'm not going to push that issue. That's a standard request that's done for everybody in Illinois, and for right now at the moment, I'm not going to push it because I don't know either side is going to be pushing that issue.

A. Thank you.

Q. You're welcome. That's all I'm asking for as to Exhibit 1 -- I'm sorry -- Exhibit A, my mistake. For purposes of today's deposition, we'll make Exhibit B the disclosure, so make this really easy. And I'll show you what I'm going to mark.

(Whereupon, Exhibit B was marked for identification.)

BY MR. BERMAN:

Q. So if you can see my screen, Exhibit B is the document in which you were disclosed as an expert witness in the case, and that's three pages. And attached there are Exhibits 1, 2, and 3, so B-1, B-2, and B-3. So B-1 is your IME report, B-2 is your CV, and then B-3 is your expert report in this case, which is three pages.

A. Okay.

Q. And then B-4 is your testimony list.

A. Okay.

Q. I'll just ask you -- I'm not going to go through your CV, Doctor. I've looked at it. It's extensive. I get it. My only question to you, Doctor, is, the one that was attached here as Exhibit B-2 for your deposition today, is that current and up to date or does that need to be made up to date with additional information?

A. It's not completely up to date, but nothing that would be added if I updated it would be particularly -- would be germane to this case.

Q. Okay, I understand that.

So let's start with what I want to talk to you about, which is essentially what information do you have in this case, what records or information did you review relative to this case. And to do that I'm going to go to again Deposition Exhibit B, which is the 26(a)(2) disclosure of yourself. Have you seen this document before by the way?

A. No.

Q. You can see that it's three pages. The reason I'm using this is because it seems to list everything that you reviewed. So I'm going to ask you to take a brief look at it and tell me if the list is accurate. So starting at facts or data considered here --

A. Right.

Q. -- in forming opinions. I can make it bigger. And go through at least one and two and tell me if you reviewed all that information.

A. I have.

Q. Okay, good.

And then 3, 4, 5, and 6, did you review all that information?

A. Yes.

Q. Is there anything that you reviewed that's not listed in this --

A. I believe I did receive something subsequently. Let me just go into my file and tell you -- what's the last date that you have of when I received things? There is 4/23/21.

Q. I don't think it tells us. Oh, it does. It says 4/23/21.

A. So on 5/20 I received Wheaton Chiropractic, two files. On 5/4/21 I received four -- no, three deposition transcripts, which I thought I saw there. Well, Jodi Rankin is one of them. For whatever reason I have these in No. 6, but it wasn't listed with a date and time. New ones that I'm showing you are -- there were two records in one PDF. One of them was from a psychologist, and for whatever reason it's not booting on my computer. Hold on a second.

I'm not sure what the problem is. I could try to do it off this computer. I have two computers here. This one doesn't want to let me go to -- here, let me try one other thing.

Q. Sometimes technology doesn't help.

A. Okay, let's try from scratch here.

Okay, now it came up. So there's a Dr. Patricia Merriman. I have two notes from her.

And I have a note from Dr. Patel that was cosigned by Dr. -- okay, here's Dr. Patel's note. By Dr. Buvanendran. Those are the only things I received. And in that same receipt of documents were a number of pictures taken by the plaintiff.

Q. So the only thing -- I've gone through this list in your Deposition Exhibit B of the documents you reviewed, facts or data considered by Dr. Prager in forming his opinions, and it's records, it's information, it's also depositions that you reviewed. Correct so far?

A. Yes.

Q. It also includes a video, the video of the -- I assume of the incident.

A. Correct.

Q. Did you view that?

A. I did.

Q. Okay, good.

It seems to indicate under No. 4 here that you were sent on 4/2/21 your own Rule 35 IME report. Is that accurate?

A. I assume so. I mean, I already had it. It's called "Records Received." Let's see on 5/2 what I have.

Q. That's the question that I was wondering. Maybe that was a mistake because it seems like it's your own report.

A. It is my own report, and it was not sent to me on that date.

Q. Fair enough.

From looking at this, you reviewed multiple depositions. I wrote it down. You reviewed the deposition transcript of Krishna Narsimhan, the plaintiff himself, right?

A. Right.

Q. You reviewed the deposition transcript of Dr. Saeed; is that right?

A. Correct.

Q. You reviewed the deposition transcript of Dr. Joshi?

A. Correct.

Q. You reviewed the deposition transcript of plaintiff's wife, Kerri; is that right?

A. That one I discussed -- no, I don't believe I've reviewed that one.

Q. Fair enough. That's why I'm going over them. You never know.

Did you review the --

A. Hold on. I just want to make sure. I know I didn't review that in preparation for today. Let me just make sure I never reviewed it.

Q. It's under No. 6 here deposition transcripts. It says, Kerri Krishna.

A. I don't have files that are organized that way.

It doesn't look like I have that one.

Q. And it is strange the way it's listed on this Exhibit B. It's listed in No. 6, Kerri Krishna, not Kerri Narsimhan. But the bottom line is you don't believe you ever reviewed the deposition transcript of plaintiff's wife, Kerri?

A. Hold on one second. One more time.

I don't believe so, no. I don't recall.

Q. And next one's listed as Jodi Rankin. Did you review the deposition transcript of Jodi Rankin?

A. Yes.

Q. Was there anything in that deposition of Jodi Rankin that you felt was relevant to your medical opinions in this case?

A. I reviewed that a while back, and I'm just trying to conjure up in my memory. But I think she did comment at that time about what his complaints

were which I had concern about, if I'm remembering it right.

Q. Well, Jodi Rankin, she was just a store employee. She was an employee of Lowe's. She wasn't a medical provider.

A. She is not the one who took a phone call?

Q. She was.

A. Right, okay. Apparently, Mr. Narsimhan explained -- at least from what I remember of the deposition, he was complaining about burning pain in his leg to her.

Q. Is that relevant to you, to your opinions?

A. Yes.

Q. How?

A. If we have an allegation of CRPS based on the injury that occurred, we wouldn't expect that by a piece of metal hitting the lower part -- or essentially around the ankle from the front would cause burning in the back. If that were to become a CRPS symptom, it would take weeks to get to that point, and it doesn't make anatomical sense, if I'm remembering that that was the source of that complaint.

Q. So just I'm understanding you for a moment

before we move on, the complaint -- if the complaint to Jodi Rankin on the day of the occurrence, you know, shortly after the occurrence was that he was having burning pain in the area where he was struck by the bar, would that affect your opinions?

A. Well, I don't remember it being that way. But hypothetically, if he had burning pain exactly where it hit, that might not be extraordinary, but if it were proximal to it, which there certainly are -- if that's the place I read it, somewhere else in short temporal proximity to the event, you wouldn't get burning pain proximal to a strike on the ankle if it were CRPS, or to tell you the truth in almost any other situation, right after being hit on the ankle because there's no way to explain why that would occur.

Q. I'm just wondering is it the location of the symptom or the type of symptom itself that's of issue?

A. Well, I think, Mr. Berman, what you're asking me is if it was -- he had burning precisely where the thing hit him, it wouldn't mean that much to me from a negative standpoint. If it's anywhere else -- now, for distal it's something else, and distal would mean going toward the toes. But that's not where he's

complaining about. He's complaining about it going up his leg, and up his leg is something that takes -- I mean, to put it in lay terms, time to percolate.

Q. Right, okay.

A. It wouldn't happen in short temporal proximity.

Q. All right. So let's go on. I was asking about depositions. I'm sorry. I took a little detour there. Sorry about that.

So you did read Jodi Rankin's deposition. Did you read the deposition of Physical Therapist Lisa Schwartz?

A. Yes.

Q. Did you review the deposition transcript of Dr. Motiwala?

A. I think you're pronouncing it wrong, but I did read that deposition.

Q. It could be pronounced different, but that's the way it's spelled so I'm going to go with it.

A. No, you put an N in there that I don't think is there.

Q. Matiwala?

A. It's Matiwala, not Mantiwala.

Q. Matiwala.

A. Yeah.

Q. That's what I thought I said, but I'm sorry if I messed it up.

A. No apology is necessary to me.

Q. I'll call her later.

All right. So the question I have is, did you review the deposition of Physical Therapist Brian Fischer?

A. I don't recall doing that.

Q. Did you review the deposition transcript of Dr. Buvanendran?

A. I did.

Q. You did, okay. That's not listed in this disclosure.

A. Are you sure?

Q. Pretty sure.

A. There it is. The records -- oh, that's Narsimhan right under there. Well, I apologize. I did review that.

Q. That's why I check.

A. Good.

Q. I missed it, too, Doctor. I'm just checking.

A. It would have been in the same batch where I got his CV, so if it's not listed there somebody made

an error.

Q. Okay. The bottom line is, you did review it?

A. Correct.

Q. Okay, wonderful.

MS. HAY: Just to be clear, Steve, I think you might have mentioned it, and I'm not sure if I see it. I was trying to pull up the document, but I'm having a little bit of difficulty. And it's hard to read the entire document you have here. But he did review Dr. Joshi's testimony, too.

MR. BERMAN: I think that was on there.

THE WITNESS: I think it was on there, too.

MS. HAY: I see it there. There it is under No. 5.

BY MR. BERMAN:

Q. At least I didn't miss that one.

Okay. Are there any other records or deposition transcripts that are not included on that disclosure that you think that you reviewed that we can update or record today?

A. Not that I know of.

Q. Terrific.

The records you reviewed, the medical records you reviewed, are those the type of records that a

doctor such as yourself could reasonably rely on in formulating opinions like this?

A. That's an excellent question, and it's not a simple answer because those kind of records are what I would attempt to rely upon pending the way things are documented -- actually, probably just the best way to put it is, depending on how things are documented, but also depending on how things were particularly done in order to allow me to fully depend upon them.

Q. Let's see if I understand your answer, and I think I do.

A. You may want to mute.

Q. What's that?

A. Somebody may want to mute because there's a siren going.

Q. That's actually coming out of my window.

A. You can't mute, okay.

Q. No.

A. Don't worry about it. If it was one of the other -- well, Judy's on mute herself.

Q. I'm going to suppress background noise.

A. It's gone now.

Q. Is that better?

A. It's much better.

Q. Good. If there's a problem with the audio, just let me know. I'll try to fix it.

So, again, I'm just going to follow up and come back to your last answer. The records you reviewed in this case you said you would normally -- are the type of records you would rely on except it kind of depends on how the examination findings are documented in the records, right?

A. Correct.

Q. So in other words, when you're reviewing a case such as this -- and you've done this before, I know -- you've come across I assume some doctors that don't document their findings as well as others; is that fair?

A. That's definitely fair.

Q. In this particular case, you reviewed the records, and did you have some concerns about how Dr. Farbman's records were documented?

A. Not particularly.

Q. In this case did you have any concern about how any of the examinations -- strike that -- how any of the doctors documented their findings or examinations relative to my client Mr. Narsimhan?

A. Yeah, I'm just trying to remember. The first

doctor in I believe 2018, the first doctor to suggest a diagnose of complex regional pain syndrome was Saeed, and I'm trying to remember if she adequately documented the criteria in order to entertain such a diagnosis.

Are you still there?

Q. I thought you were looking up something to answer the question regarding Dr. Saeed's initial diagnose of CRPS. I was just waiting for you honestly.

A. Sorry. I was waiting for you. I was just saying that based on my recollection I don't remember seeing in her notes sufficient documentation to establish a diagnosis of CRPS.

Q. You mentioned you received records from a Wheaton Chiropractic Clinic, I believe?

A. That's correct.

Q. Was there any records of information contained in those records that was of relevance to your opinions in this case?

A. Yes.

Q. What?

A. That throughout that treatment that was -- I'm just tying to remember how long. It was, I

remember, about three months of treatment. If I remember right, in 2016 from September to December, he was being treated for pain. And if I remember right, there were about 20 of those visits during that three-month interval, and not once was there a complaint of leg pain.

Q. What was he being treated for during that time frame?

A. His arms and hands.

Q. At Wheaton Chiropractic?

A. If I remember right, yeah. Why don't we go there and see.

Sorry it's taking so long. Maybe if I did a search under Wheaton, it would come up quicker. There it is, okay. So here we have -- that one is not useful.

Well, here, just if we look at -- I'm looking for the date of this form that Mr. Narsimhan filled out himself on it looks like 5/20/16. It's a little hard to read how he filled out the form. But nonetheless, at some point in 2016 -- oh, it's 9. He just makes a funny 9. He fills out a form on 9/20/16 where it says, "pain and numbness or cramps," and he puts in his hands but he doesn't put in his feet or

his legs either. It's only his hands.

Q. Okay.

A. And he indicates that he has moderate frequency and moderate intensity. And then the examination report -- okay. Well, here's a patient progress report dated 10/11 where the only complaints that he fills out or that are filled out relate to the arms and shoulders, and there's nothing on the legs. And what I can tell you is, I have 68 pages of notes. During the course of reviewing those 68 pages of notes -- and here is a form. I believe this was filled out by the patient himself. He's only complaining of pain in the wrist, hands, and neck of recurring -- yeah. And here is a note, a typed note, thank God, left wrist, left forearm, so his complaints are completely limited to his upper extremities. And what I can tell you -- we can go through all these notes, but I think it's wasting your time and money to do it because my best recollection of all these notes -- I mean, here, we'll go to one of the last notes, neck, arms, wrist, diagnoses, cervical, cervical, forearm, okay, and that's December. So now we've just spent three months, and we're only up to page 22. And what I can tell you is, I've been

through all these notes and not that recently, but it was important to me when I went through them that there was nothing related to his lower extremities, although he's very vocal about the pain and numbness in his upper extremities.

Q. Okay, I understand what you're saying. From your experience, Doctor, do chiropractors typically treat neuropathic pain?

A. That's what apparently they were treating him for here in the upper extremities, pain. I mean, I think your question is a good question. I'm not sure why he's referred there in the first place.

Q. I'm asking you, in your experience, in your opinion, do chiropractors treat neuropathic pain?

A. They can. It's not what they usually treat.

Q. Do chiropractors treat CRPS?

A. Unfortunately I've seen the case where they have, but I don't think it's a good idea.

Q. I hear you.

All right, let's move on. I'm going to ask you about some of the doctors that names you're familiar with in this case, and the question is going to be for each one: Are you familiar with one of those doctors or medical professionals personally or

by representation, okay?

A. Okay.

Q. Let's start with Dr. Farbman, are you familiar with him personally or by reputation?

A. No.

Q. What about Dr. Saeed?

A. No.

Q. What about Dr. Motiwala?

A. No.

Q. What about Physical Therapist Brian Fischer?

A. No.

Q. A Physical Therapist Lisa Schwartz?

A. No.

Q. What about Dr. Buvanendran?

A. It's interesting because I think his name may have sounded slightly familiar to me. And I looked him up, and so I have some idea who he is. But very interestingly we were both on a conference call last week. But he did not say so much as one word, and he didn't put his camera on. I believe that was him. I can't say that for sure, but I believe it was. But his camera wasn't on, and he didn't say a word. And that's the only contact I remember having with him.

Q. To be fair, with regard to Dr. Buvanendran,

you don't know him personally?

A. Correct.

Q. And what, if anything, can you tell me you know about Dr. Buvanendran from a professional reputation standpoint?

A. I think he has an interest in CRPS.

Q. Other than that, anything else?

A. He's on the faculty of Northwestern, if I remember right. He's a medical faculty member.

Q. Anything else?

A. I believe he's esteemed in his field.

Q. Okay, fair enough.

I know that you, Doctor, are one of -- I don't know if I'm phrasing this right, but one of the few doctors who performs a dorsal root ganglion stimulation procedure; is that accurate?

A. Yes. At the time whatever was written said that that was the case. More people are doing it now.

Q. Dr. Buvanendran is one of those doctors who performs that type of dorsal root ganglion stimulation procedure, correct?

A. I believe so.

Q. I'm going to ask you about -- before we get into the meat of your testimony, I'm going to ask you

a little about your overall review of -- your time reviewing this particular case. Can you tell me how much time it took you to review all these records we were just listing earlier?

A. Well, I have to say to you, Mr. Berman, that unfortunately it's never been tabulated. And I do most of that work from home, and I didn't bring those individuals tabulations. And what I can promise is, well before trial you will have a summation of all that, but it hasn't been done. The only thing I've invoiced the defense for is my hotel and air.

Q. Okay, all right. So let me switch gears and do it this way. Maybe this will be a shorthand version for you. I'm going back to Exhibit B. In Roman numeral six, "a statement of the compensation to be paid," and it lists your compensation schedule. Is this accurately listed?

A. Well, the independent medical examination is not because it was on out-of-town one, and that's my fee for in in-office medical exam. So the other one is a much higher fee.

Q. What was the fee you charged defense counsel for your independent medical examination of Mr. Narsimhan?

A. Well, if you're going to be legalistic, I haven't charged them anything else.
Q. What fee will you be charging?
A. Yeah, it was two days of my time at $8,000 a day.
Q. So $16,000 total for the IME?
A. Correct. Well, the IME and travel to be fair.
Q. All inclusive?
A. Correct.
Q. Does the rate for performing an IME include the report itself as well, or is that extra?
A. No, that's all inclusive.
Q. Your deposition time, is this accurate, $1,500 per hour?
A. Correct.
Q. Does that start when the deposition starts?
A. Yes.
Q. So in terms of say, for example, time preparing, time reviewing records and getting ready for today's deposition, is that charged at the 960 per hour rate?
A. Correct.
Q. Then I think you said you haven't prepared

and invoice, but you will. And that will include specific listings of the amount of time you spent reviewing records, consulting with the attorney, preparing for the deposition, all at that $960 per hour rate, right?
A. In excruciating detail.
Q. And I know you said that you performed -- strike that.
I know you've been retained as an expert witness not just in Illinois or California but throughout the country; is that right?
A. That's correct.
Q. And is that because you're a recognized expert in the field of CRPS?
A. Well, it's not only CRPS. I have expertise in spinal cord stimulation, precision spinal diagnostics and therapeutics, intrathecal pumps, yeah. But, you know, Mr. Berman, you're predominantly right, probably 80 percent of that retention is related to CRPS, but my expertise in spinal cord stimulation is comparable to my expertise in CRPS.
Q. I understand. And also you're a practicing medical doctor in the field of pain management at this time as well, right?

A. That's correct.
Q. So you see patients, right?
A. 80 percent of the time.
Q. Okay. In terms of -- so just take out the times when you're a treating medical doctor, and the times -- I'm just going talk to you about the times you're retained as a medical expert witness in litigation. For the times you're retained as a medical expert in litigation, what percentage of the times are you retained by a representative of the injured party versus the times you're retained by someone who the injured party has a claim against?
A. Okay. I'm going to give you a complicated answer that I'm sure you'll be happy. I am retained initially by the plaintiff probably about two-thirds of the time. When it comes time for a designation, I am retained -- or the retention is maintained about 60 percent by the defense and 40 percent by the plaintiff. If you want an explanation, I can give you why that is.
Q. I'm not sure even what that means. Can you explain that?
A. Yeah.
Q. The designation.

A. By the end, let's say trial, it would be 60 percent defense. But there's an attrition, for lack of a better word, of many of the plaintiffs' cases before we get to that point.
Q. Got it. I didn't realize.
In terms of your work as a medicolegal expert, how much money do you earn or generate per year say over the last four or five years?
A. I'm prepared to discuss that in percentage, and in percentage up until last year, I was estimating somewhere around 16 percent because 20 percent of my time is not caring for patients. And of that 20 percent, about 80 percent of it is medicolegal. So up until last year it was about 16 percent. But during COVID my medical practice decreased, so the percentage of medicolegal percentage-wise went up over 20 percent. Do you follow that?
Q. Not really. When you answer in percentages, it doesn't really answer my question because it's too vague, so I'm just going to ask you to answer the question that I asked. If you want me to repeat it, we can repeat it.
A. Well, I think I understand the question. And we don't break it out here the way revenue comes in,

so I don't really have a full answer. My estimate is about up until last year under 20 percent, and with COVID over 20 percent.

Q. All right. If I'm understanding what your answer is, you're saying that your revenue that relates to medicolegal work specifically, not treating patients, is 20 percent of your income; is that what you're saying?

A. I'm saying that, yeah, up until last year it was. This year, now that my practice is busy again, the percent of medicolegal is going down again. But last year -- I think you understood what I said -- that because my practice income went down and the medicolegal practice stayed about the same, I had a higher percentage of medicolegal than I had in any other prior year because I just -- my medical practice income was substantially reduced.

Q. So then if we're going back to 2019 and you're saying that 20 percent of your practice's income relates to your medicolegal work only, what's the total practice income so I can figure out the 20 percent of it?

A. Well, that we would have to have a discovery referee tell you that that's necessary for me to tell.

Q. So you won't -- you could answer that question, but you won't?

MS. HAY: I think the doctor -- just a second, Doctor.

I think the doctor already testified that he couldn't estimate those specific numbers because his practice isn't set out that way, so I think he's already answered that.

MR. BERMAN: I don't think he answered that specific question. I think he changed the question. Can we have the doctor answer the question specifically?

MS. HAY: Sure. I think he already asked and answered it. But, Doctor, you can answer it again.

THE WITNESS: What I said is that I don't know that that is information that -- it appears to me that that's an invasion of privacy, and that -- I've been asked the same question probably 20 times, and in all 20 times including federal court when I've declined to answer that question, the judge has vindicated my decision to do that.

BY MR. BERMAN:

Q. All I'm asking you right now is you understand that the question is, in 2019 what was your

total practice's revenue so that we could figure out the 20 percent of that as just your federal, you can answer that, but you wouldn't because you think it's an invasion of privacy; is that fair?

A. Correct.

MS. HAY: Note my objection based upon the doctor's answer.

BY MR. BERMAN:

Q. Would that be true for 2018 as well, Dr. Prager?

A. It would be true for all years.

Q. For this particular case, can you tell me the name of the law firm that initially retained you?

A. Yes, it was Lewis Brisbois.

Q. My question for you, Doctor, have you ever been retained by any attorneys from the firm Lewis Brisbois other than in this case?

A. Not in Chicago.

Q. What about in any other city?

A. I've probably done two or three cases for Lewis Brisbois' Los Angeles office.

Q. And have those other two cases that you've been retained by defense counsel Lewis Brisbois, have those been retentions on behalf of a defendant in a

case?

A. I cannot swear to that, but I believe that that would be true.

Q. What about defense counsel that's currently handling the defense of this case Hepler Broom, have you ever worked with that law firm before?

A. I don't believe so. We could ask Ms. Hay if I -- and then I would testify to whatever she tells me, but I don't know of any. I guess only the --

Q. You shouldn't say that, by the way.

A. I think it's only the second case I've done in Chicago.

Q. All right. Turning your attention to Mr. Narsimhan and his case specifically.

You understand from your review of the records that Mr. Narsimhan was involved in an incident on June 25th, 2016, in which he was at Lowe's and a metal bar fell onto his right lower extremity just above the ankle, right?

A. Correct.

Q. And you saw the video of that; you know that that incident occurred, correct?

A. Correct.

Q. As far as you reviewed the records of this

entire case and your entire knowledge of Mr. Narsimhan and his life, is it fair to say that you have no knowledge of Mr. Narsimhan complaining of any prior right lower extremity pain or symptoms prior to the incident of June 25th, 2016?

A. That's correct.

Q. You agree that the impact between the metal bar and Mr. Narsimhan's right lower extremity was a traumatic impact?

A. That's an interesting question, because to a layperson the word "traumatic" has big meaning. To a physician, it just means something out of the ordinary essentially. And so we have minor trauma, moderate trauma, severe trauma, and just so that I'm clear on what I'm expressing, I would consider this a minor trauma.

Q. What was the weight of the metal bar that landed on Mr. Narsimhan?

A. I don't remember.

Q. What was the speed at which it contacted Mr. Narsimhan's right lower extremity?

A. I haven't read a biomedical or bioengineering analysis to know the answer to that.

Q. If you don't know the weight of the bar or

the speed at which it contacted Mr. Narsimhan's right lower extremity, why do you call it a minor or minimal impact?

A. Because I saw the video.

Q. Any other reason?

A. That's a good reason.

Q. Any other reason?

A. No.

Q. You saw in the medical records that since the incident -- sorry. You saw in the medical records and deposition testimony that since the incident of the impact between the metal bar and Mr. Narsimhan's right lower extremity, he has been consistently complaining of pain and symptoms of discomfort in that right lower extremity, correct?

A. No.

Q. That is not correct?

A. It's correct that it's not correct.

Q. When was Mr. Narsimhan's pain or discomfort healed such that he wasn't complaining of any pain or discomfort in that right lower extremity?

A. During the interval at least from 9/16 to 12/16, but I actually don't see complaints really until -- well, there were some complaints, but I

didn't see anybody entertaining a diagnosis of CRPS for over two years following that incident despite the fact that there were intermittent complaints of pain. But then there were sustained periods, or at least one sustained period where there wasn't, but I believe there were other periods where there were no complaints.

Q. Did you review Dr. Farbman's records, correct?

A. I have.

Q. And he treated Mr. Narsimhan in July 2016, August 2016, October 2016, February 2016, March 2017, May 2017, April -- I'm sorry -- August 2017, February 2018, April 2018, May 2018, and June 2018. You saw those records, correct?

A. I did.

Q. And throughout those records were locations of complaints of pain in the right lower extremity. Do you acknowledge that?

A. Well, throughout might be a stretch, but there were intermittent at least complaints of pain in the right lower extremity.

Q. In what record did you ever see in Mr. Narsimhan's case that says his right lower

extremity pain had gone away?

A. Well, I don't think there was one where it said it went away, but I think there were ones where there were not descriptors of it. And I would have to look that up to find out specifically when that was.

Q. When you said -- I think what you said to me was that in the chiropractic records there was no description of right lower extremity pain, correct?

A. I did say that, yes.

Q. Is it your opinion then that during the time that Mr. Narsimhan was seeing a chiropractor for his neck and upper extremities that he was therefore not experiencing pain in his lower extremity?

A. Well, I mean, you're the lawyer with res ips, or I think that's the term, that if you see it -- well, if it's not documented, then it's not there.

Q. That's not what res ipsa is, Doctor.

A. No, I know. I realize it. That's why I took it back.

Okay. So here I'm just looking here for the date of this evaluation.

Q. Doctor, I know we're pausing here. I'm waiting for you. Are you still --

A. That's correct. I was looking to see if in

Dr. Farbman's notes, I could find -- I mean, he was talking about pain there. He wasn't entertaining a diagnosis of CRPS. He was talking about -- well, he was mentioning the diabetes, if I remember right. He was mentioning peripheral neuropathy with numbness, which is not a sign of CRPS. And contemporaneously and previously he was being seen by Dr., I think his name was Ignatius at Northwestern from 2012, 2015. Then in 2016 just before this incident, he began to be seen by the doctor that you pronounced the name wrong Matiwala. And Dr. Matiwala was constantly discussing the need to better maintain glucose control, and Dr. Matiwala was -- who's I believe a general practitioner, an internist, not a neurologist and not an endocrinologists as misstated by one of your experts. But Dr. Matiwala was just working really hard to get good insulin control or good -- he said the insulin dosage had not changed in many years. He wasn't monitoring his glucose. He was gaining weight. He wasn't watching his diet. So there was a lot of things contemporaneously going on that went on beyond the period where this incident occurred.

Q. Doctor, I think you're getting pretty far from my actually question, so let me see if I can

narrow it down. What I'm wondering is -- I know you reviewed records from before and after the incident of 6/25/16. My question for you is, in the records reviewed after 6/25/16, was there any doctor or medical practitioner who noted that the right lower extremity was healed or that the pain had gone away?

A. Well, I think another way of putting it was were there consistent complaints in the records of those doctors that there was pain. Because the way those charts are set up, there aren't problem lists where then you say problem terminated, so whatever they were focusing on that day, whether it be arms and hands, were what they were discussing. And if they weren't discussing the leg at that time, they weren't discussing the leg. It doesn't mean one way or another whether it went away or didn't went away. It just meant that it wasn't enough of an issue that it would be in the record.

Q. Sorry, Doctor. I'm going to ask you to answer the question the way it's phrased, if you can please.

Can we have it read back, Judy?

(Whereupon, the record was read as follows:

"Q. Doctor, I think you're getting pretty far from my actually question, so let me see if I can narrow it down. What I'm wondering is -- I know you reviewed records from before and after the incident of 6/25/16. My question for you is, in the records reviewed after 6/25/16, was there any doctor or medical practitioner who noted that the right lower extremity was healed or that the pain had gone away?)

THE WITNESS: Okay. I mean, the construct of the question makes it hard to answer. And so with that introduction, what I will say is, no one made it go away -- but I want you to include this in my answer -- no one said it went away but there were times where nobody described the problem.

BY MR. BERMAN:

Q. And you read Mr. Narsimhan's deposition in which he indicated in his deposition that from the time of the incident of June 2016 up until the time at least his deposition was given he had consistent pain

in his right lower extremity, correct?

A. Correct.

Q. Mr. Narsimhan himself has indicated that the pain -- (audio interruption) -- any period of time when the right lower extremity pain had gone away or healed subsequent to the incident, correct?

MS. HAY: Excuse me. Steve, could you just repeat that question? You were cutting out just a little bit.

BY MR. BERMAN:

Q. Upon reviewing Mr. Narsimhan's deposition testimony, you would agree that at least Mr. Narsimhan has indicated that he has had consistent pain in his right lower extremity only since the incident of June 2016, correct?

A. He has said that, yes.

Q. And there is no medical documentation to prove otherwise, correct?

A. Well, I actually just provided you documentation otherwise. If we look at Wheaton Chiropractic, there's a three-month period where he is being actively treated for pain, tingling and numbness, and at no point is the leg ever brought up.

Q. All right. So the fact it's not brought up,

I think you said already that that's not an indication he was not complaining of pain in his leg; it's just that it wasn't being treated at the chiropractic clinic?

A. No, he filled out a form himself, okay, in his handwriting with his signature where he did not -- where they asked him. I mean, it was a diagram and a table where his diagram of his pain only included his hands, and the table where you could check off leg or foot was not checked off. So that was not only the facility or the chiropractor himself, but it was also Mr. Narsimhan not filling in leg pain.

Q. Okay. So if Mr. Narsimhan didn't fill in leg pain because he wasn't at the chiropractor to treat his leg pain, he was being treated for the leg pain by the neurologist, would that affect your opinions in any way?

A. No.

Q. From your entire review of this case, are you aware of any other traumatic incident or event that injured Mr. Narsimhan's right lower extremity other than the incident at Lowe's in June of 2016?

A. That's a very good question, and I am not.

Q. From your review the record, would you at

least agree that the impact between the metal bar and Mr. Narsimhan's right lower extremity at Lowe's caused Mr. Narsimhan pain?

A. I agree with that.

Q. You have an opinion as to the diagnosis of the pain that the incident of the metal bar hitting Mr. Narsimhan in right lower extremity, what it was?

A. I think you got garbled again there. I don't know if anybody else heard it, but I couldn't hear it.

Q. Okay. Let me ask you some general questions first. As a recognized expert in CRPS, would you agree that in most patients CRPS is a chronic condition that can be permanent?

A. It is a chronic condition that can be permanent that can also go into remission.

Q. In what percentage of cases that you're aware of are symptoms of CRPS permanent, and in what percentage of cases do those go into remission completely?

A. In my practice more than 50 percent of the patients go into complete remission.

Q. When you say --

A. It doesn't mean they don't come out of complete remission. But they go into complete

remission, and we follow the ISP treatment guidelines in how we get there.

Q. Are you talking about -- you said greater than 50 percent of your patients go into remission at some point. Is that 51 percent, 60 percent? How would you further characterize it?

A. It's the majority. And I can tell you that my largest referral source for CRPS and our comprehensive interdisciplinary functional rehabilitation program is the workers' compensation system of the state of California because we get such a high percentage of patients back to work. And what I can tell you is in the occupational health literature, people who have been out of work for greater than a year only have an 18 percent chance of going back to work ever, and that we get more than 50 percent of our patients go back to work. And the savings they have in terms of not having to pay future wages are substantial.

Q. That's fine. You didn't answer my actual question, so I'll rephrase it.

A. I answered.

Q. My question is, you say that your clinic gets greater than 50 percent of patients into remission at

some point, and I'm wondering what that percentage is. What does that mean?

A. I don't have an exact number, but it's more than half.

Q. So there's some percentage less than half of patients that never go into remission of CRPS patients?

A. Well, if you want -- I can tell you that the vast majority, like probably over 90 percent get substantial remission even though they don't get complete remission.

Q. Would you agree that a patient has a better -- a CRPS patient has a better chance of achieving remission of symptoms if the systems are recognized early and effective treatment is initiated early?

A. Yes.

Q. In your opinion, when is the best -- from an early standpoint, when is the best time to recognize the CRPS and begin treatment of it?

A. Three months.

Q. Would you also know that patients who are in their teens or 20s have a better chance of achieving remission of CRPS symptoms than other patients?

A. Achieving 100 percent remission, yes.
Q. In your practice do you use Gabapentin as treatment for resolving CRPS pain?
A. Well, not -- resolving is probably not an appropriate term. It is one of the medications that we use in the treatment of CRPS, as well as other neuropathic pain conditions including diabetic peripheral neuropathy.
Q. So you're saying that Gabapentin is used to treat CRPS, as well as other types of neuropathy such as diabetic neuropathy pain, correct?
A. Right. And in fact Gabapentin is FDA approved for treating at least two neuropathic pain syndromes of which CRPS is not one of them, and nonetheless, we use it.
Q. That was my next question. As a recognized expert in CRPS, in your clinic you use Gabapentin as a treatment -- one of the treatments for CRPS pain, right?
A. Right. It's my number two treatment pharmacologically.
Q. In your experience, though, using this particular drug Gabapentin, how effect is Gabapentin in terms of resolving CRPS pain 100 percent?

A. Well, I mean, we keep coming back to resolving the CRPS pain. I don't think Gabapentin resolves any kind of pain. Gabapentin treats pain successfully, and the limiting factor on Gabapentin is not any kind of toxicity. It's just side effects that are not permanent, and they're not dangerous. But they exist, and that is the limiting factor in using Gabapentin.
Q. I'm not asking you about ketamine yet because I might ask you about that in a minute. But let's stick with Gabapentin for just a moment, Doctor, if you could. In your practice or just in general, can you tell me how effective Gabapentin is in bringing CRPS symptoms into remission like we were talking about, remission?
A. I would say zero bringing it into remission.
Q. So is it accurate to say that Gabapentin is used to help minimize the symptoms of CRPS pain?
A. Yes, and also to be a tool to allow other treatments to do what you were talking about to help get people in remission. Gabapentin by itself will not get you into remission, but it may sufficiently alleviate the pain to allow you to participate in a functional rehabilitation program that can then get

you into remission.
Q. You said Gabapentin is also used for diabetic neuropathies. In your opinion is Gabapentin more effective treating diabetic neuropathy?
A. I think it's equally effective. It's just what I was saying before, Mr. Berman, that it's approved for two neuropathic pain conditions by the FDA. It doesn't mean it doesn't work in other situations. And in terms of comparable amount of pain, I would say it's equally effective in diabetic -- it's very hard to measure pain, but by the way the patient describes the pain to you, if they were describing it with an etiology of what we call DPNP, diabetic peripheral neuropathy pain, or CRPS pain, the same degree of pain would be treated comparably.
Q. I'm going to ask you about CRPS symptoms and signs, and you know those are two different things, right?
A. I sure do. Most don't. Very good.
Q. I'm going to ask you this question, and if you don't like the way it's phrased, just let me know. I'll break it up. But I want to just ask you generally, in your experience can CRPS symptoms and

signs wax and wane from day to day or week to week?
A. Yes.
Q. Can CRPS symptoms and signs wax and wane even throughout the day?
A. Yes.
Q. In your experience can CRPS patients have some good days and some bad days?
A. Yes.
Q. In your experience can CRPS patients have some good days where they have less symptoms and signs than they have on their bad days?
MS. HAY: I'm sorry, Steve. Could you repeat that question?
THE WITNESS: That one got garbled again.
BY MR. BERMAN:
Q. Can CRPS patients have some good days in which they have less symptoms and signs of the CRPS than they have on their bad days?
A. I think that's kind of asked and answered, but the answer is still yes.
Q. I'm still on some of these general questions. This dorsal root ganglion stimulation issue, DRG, that's a surgical procedure; is that right?
A. Correct.

Q. That's an invasive procedure, right?
A. Correct.
Q. Are there certain potential surgical complications that go along with that DRG procedure?
A. Something you didn't ask -- at the beginning you said you're one of the few physicians in the country that perform it. I stopped performing it and do an alternative procedure because of exactly what you're saying.
Q. So what are the potential surgical complications of the DRG procedure that caused you to stop performing?
A. Well, there are a few things. One is not -- two of them are not officially complications as defined. But I've had a hardware failure in multiple -- multiple kinds of hardware failure including a year later having the lead pull out of the pulse generator so it needed surgical revision. I've had multiple leads fracture. And you could call those complications, or you could just call them equipment malfunctions. But regardless of what they are, they require surgical revision, another surgery. But the third one is that in placing the dorsal root ganglion lead there is a risk of hurting a nerve, and that's

probably the principal reason that I stopped doing it.
Q. But also as a surgeon, would you consider that the potential for infection is a potential surgical complication of DRG?
A. It depends. Yeah, officially when I have to read and when I go over the risks and benefits of any surgery, I have to tell patients that there is a risk of infection, but we have an extreme -- I also in my practice, unlike cases that I review sometimes in medical malpractice, we have an extremely low, below 1 percent infection rate requiring explantation.
Q. Doctor, in your experience, with your knowledge of this procedure, the DRG procedure, do you know what the usual and customary and reasonable cost of such a procedure is?
MS. HAY: Just object to form and foundation.
THE WITNESS: Yes.
BY MR. BERMAN:
Q. What is it?
MS. HAY: Same objection, but you can answer, Doctor.
THE WITNESS: Okay. Well, we have to -- there are a minimum of three kinds of charges for performing the procedure. One is called the facility

fee; the other one is either called a technical fee or professional fee; and the third one is the anesthesia fee. And for a trial the professional fee can be anywhere between $1,000 and $9,800 as far as what I've seen. And just so you know, Mr. Berman, I actually do reviews for insurance companies, so I have a pretty good idea of this. I also see lien fees that are multiples of these numbers that I quoted you, but these I don't feel are legitimate fees.
BY MR. BERMAN:
Q. That's what I asked you in your opinion what is a reasonable fee, not a --
A. Okay. Professional between 1,000 and 9,800. For the lead placement, facility, anywhere between 5 and $20,000. For the placement and anesthesia, anywhere between 500 and $1,000.
Q. Is that for the trial of the DRG or permanent implantation?
A. I just gave you numbers for the trial.
Q. What about for the permanent implantation after the trial is completed?
MS. HAY: Just note my continuing form and foundation objections, but you can answer, Doctor.
THE WITNESS: Professional fees, anywhere

between probably 3,500 up to 15,000. Facility fees within reason, anywhere between 28 and 40,000. Anesthesia fees anywhere between 750 and $1,500.
BY MR. BERMAN:
Q. And, Doctor, because there was a foundation objection by Ms. Hay, I want to just make sure you and I were clear. I mean, you were explaining this before. You are aware of this procedure; you are aware of the cost of the procedure in your practice; and also you review these costs for insurance companies so you're aware what the usual and customary and reasonable costs are. Is that fair?
A. Just as you were distinguishing between signs and symptoms, I will distinguish between costs and charges. I think the word you wanted to use was charges rather than costs. Because somebody charges an amount, it doesn't mean they get it. And what they get paid is the cost, but what they charge is what they charge.
Q. In your experience, you can review the charges and make a determination of whether that's what's within the realm of reasonable charges or not, right?
MS. HAY: Same ongoing objections.

THE WITNESS: Right.
BY MR. BERMAN:
Q. And what you were explaining to us earlier were what you consider reasonable charges for such a DRG procedure, correct?
A. Correct.
MS. HAY: Please note all my continuing objections to all of those questions with regard to costs and charges.
BY MR. BERMAN:
Q. Also, I know that you are a recognized expert in ketamine and use of ketamine to treat individuals with CRPS; is that right?
A. Correct.
Q. And you still continue to use that type of treatment, the ketamine treatment to help reduce symptoms or put CRPS symptoms into remission; is that accurate?
A. Not only symptoms, but signs.
Q. Fair enough. So both?
A. Both.
Q. Let me ask you about that for just a moment. Ketamine treatment, are there some potential side effects or potential risks of that type of treatment

for CRPS symptoms and signs?
A. Again, I think it depends on who is administering it because I'm certainly -- we spent about 10 years looking at all possible side effects to see how they could all be mitigated, and I think we have a special sauce so that they all can be mitigated. In terms of actual risks, there is a risk of hepatic injury or liver injury that if you're careful on how you do it; in other words, periodically monitor liver function, if you discontinue it before it becomes a real big problem, it resolves on its own. And, in fact, in our practice, we've noted a few patients that started to have changes in their liver function discontinued, and within a few weeks their liver function was back to normal. That's why I said it depends on whose hands it is, because unfortunately there are, for lack of a better word, cowboys out there that don't read the literature and don't really care for pain patients but only want to administer ketamine infusions for their own personal reasons who don't really do it as a true physician should and wind up with complications. But in the people that I know around the country who are administering ketamine, they're administering it carefully and not having

complications.
Q. In terms of the ketamine treatment that you're familiar with, because you're an expert in it, is this an infusion that's only a one-time infusion; is it multiple times? How long does it take, in other words, and how many treatments does the ketamine take to get the desired effect of reduction or remission of symptoms?
A. Okay. That's a very complicated answer. And this is one where I do give lectures, and the lectures take up a whole hour. Now, all of that whole hour aren't exactly on the question you asked, but it's a more complicated answer than you may want to hear right now. I'll try to give you an abbreviated answer.
Q. If you could simplify it for me.
A. Okay. So there are three different ways at the minimum of administering intravenous ketamine. One is the one-day infusion followed sequentially by others; the other is the 24-hour continuous inpatient infusion that is not coma; and the third one is ketamine coma where the patient has a breathing tube put in the ICU for five days and undergoes very high dosage ketamine treatment with general anesthesia

simultaneously.
What is the most common are the daily infusions, and Dr. Schwartzman who wrote the first articles on this advocated 20 consecutive daily treatments at a relatively low dose that he was doing given the manpower he had administering it with him. There are very few -- I don't know if anybody still -- his studies demonstrated efficacy under those circumstances, but I don't know of anybody doing 20 days of infusion because it's cost prohibitive.
So the more common way, as I mentioned, Mr. Berman, is to do up to ten days of infusions. And I'll just tell what you our protocol is. We do a three-day trial, three consecutive days with escalating dosages on each day. And at the end of three days if on the fourth day the patient still appears to have some benefit a day after the third infusion, we consider then doing a full course of ten, but we don't want to obligate the patient to ten days if it doesn't look like it's going to work. Now, what I can tell you is that probably 80 percent -- and I don't have the exact number. But the vast majority of patients after the three-day infusion proceed to the ten days with the infusion.

Now, what the literature shows is, if you have a successful ketamine treatment -- and in our practice it would be the ten-day course -- that 50 percent of the patients have sustained benefit so that they never have to get any ketamine again. And the remaining 50 percent usually require booster infusions, which the longest -- well, that can be either monthly or every three months for years.

Q. Let's just talk about that sort of common example of ketamine treatment that works, the ten-day treatment. Do you have knowledge of the reasonable and customary type of cost of that ten-day ketamine treatment?

MS. HAY: I'll object to form and --

THE WITNESS: Yes.

MS. HAY: Just one second. I'll object to form and documentation given the doctor's locale, but you can go ahead and answer, Doctor.

THE WITNESS: Yes, I see variability between 500 and $2,500 per infusion.

BY MR. BERMAN:

Q. And I know that you talked about your understanding of these costs as an expert in this field. Would your understanding of the usual and

reasonable costs, the reasonable charges differ between California and Illinois and New York and all over the country?

A. The problem is, Mr. Berman, this is not something I have the opportunity to review because none of the guidelines for treatment of any kind of problems aside from depression -- well, none of them -- no guidelines include ketamine infusions for treatment of pain, headaches, or depression, no guidelines do. So insurance companies tend not to pay for it except by exception, and I've not had the opportunity ever to review billing for that. But I speak at ketamine conferences, and I speak to the people who are the active ketamine practitioners in the country. And I have an idea about what people charge.

Q. And that's throughout the country, right?

A. Yes.

Q. So for the DRG you're familiar with what people charge throughout the country, correct?

A. Yes.

Q. Understood.

I'm going to switch gears for just a moment. I'm finished talking about the ketamine for now. Now

I'm going to switch gears and ask you about diabetic neuropathy. I know some of your opinions in this case relate to diabetic neuropathy. Is it your opinion in this case that Mr. Narsimhan's symptoms in his right lower extremity relate to diabetic neuropathy?

A. Yes.

Q. And you've treated diabetic neuropathy pain and symptoms before, right?

A. Right. I'm a board-certified internist, and I have treated diabetic neuropathy and diabetic neuropathic pain long before I ever became an anesthesiologist and subsequently became a pain physician. So I was actually an attending physician in internal medicine, practiced internal medicine.

Q. And that's good. That background's important because the question I have is, how do signs and symptoms of diabetic neuropathy differ from signs and symptoms of CRPS, if at all?

A. Well, the symptoms are the same predominantly. The signs can be different. Both can get thinning skin certainly. Both can get peripheral hair changes. With diabetic neuropathy, there are other things that can simultaneously be occurring that can cause compromises in calculation, and that's

actually very common. And sometimes the compromise in circulation can create pain that's as bad as the peripheral neuropathic pain. In many ways they're similar, but you can even get sometimes the trophic changes in diabetic peripheral neuropathy. You can certainly get swelling in diabetic -- well, you can get swelling in diabetes where the extremities are involved, whether it's the diabetic peripheral neuropathy that's causing that problem or the diabetes that hasn't been well controlled. So I think that's -- we can dig in a little deeper later, but I think that should probably be telling you what you want to know.

Q. Yes, yes. The reason I asked you the initial question is, I'm wondering in your practice or in your work as an expert witness, have you seen times when diabetic neuropathy has been confused for CRPS and vice versa where CRPS has been confused as diabetic neuropathy?

A. Actually in my neuropathy, which is far more limited than my clinical practice, I have not seen that before. But it's actually not uncommon for patients to get referred to me from the community where somebody thinks the patient has CRPS, but, in

fact, they don't. And it's a substantial percentage -- although 80 percent of the patients that I see in my practice are referred to me for potential diagnosis of CRPS, a significant percentage of them don't have CRPS.

Q. Just to make sure -- just so I'm asking the right question, Doctor, I want to make sure I understand you. In your practice have you seen times when other doctors have diagnosed CRPS when, in fact, the actual diagnosis should have been diabetic neuropathy?

A. Yes.

Q. Have you ever seen times when doctors have diagnosed diabetic neuropathy when, in fact, the diagnosis should have been CRPS?

A. Yes.

Q. You've seen both, okay.

And in this case, in this Narsimhan case, you've seen doctors such as Dr. Buvanendran, Dr. Saeed, Dr. Joshi, their diagnosis in this case that Mr. Narsimhan had right lower extremity CRPS; you've seen that, right?

A. They have said that, yes.

Q. And in your opinion, in fact, the diagnosis

shouldn't be CRPS; it should be right lower extremity diabetic neuropathy; is that correct?

A. DPNP, yeah. More than just diabetic peripheral neuropathy, but diabetic peripheral -- we call it DPNP, diabetic peripheral neuropathy pain.

Q. DPNP?

A. DPNP.

Q. Got it, okay.

And in Mr. Narsimhan's situation, in his case, in your opinion, Doctor, after reviewing the entire record, what brought upon the symptoms of his DPNP?

A. The diabetes out of control.

Q. When did the diabetes become out of control such that the DPNP began?

A. Well, he had DPNP treated by Dr. Farbman in bilateral upper extremities for quite a period of time preceding the incident at Lowe's. And what's really important to understand, Mr. Berman, is that diabetic peripheral neuropathy and DPNP both tend to show themselves in the longest axons. Axon being a nerve, okay. And so it's usually more common to see it in the legs first than the arms, but if you have it in the arms, it usually shows up in the legs shortly

thereafter because the legs have longer nerves than the arms do.

And, you know, just for you to understand, you know, you don't get DPNP in your chest wall where the nerves are very close -- you know, where they come out is very close to where they wind up. You don't get DPNP on your lips. But you do get DPNP in your hands and feet very commonly for people who have uncontrolled diabetes.

Q. And from reading the records that reflected that at the time just prior to the incident Mr. Narsimhan was being referred to the neurologist Dr. Farbman for bilateral wrist carpal tunnel syndrome. Is that what the records shows?

A. I don't remember that that was the only thing, and I don't remember that the EMG necessarily showed that.

Q. I'm not saying what the actual diagnosis was. I'm saying that's what he was referred to Dr. Farbman for.

A. I don't recall that. We would have to find the exact time and date of the note, and you can put it up on the screen to show me that. Because that's not what I remember, but I won't swear to it.

Q. All right. In your opinion, however, as of July 2016 and prior even to that, is it your opinion that Mr. Narsimhan did not have carpal tunnel syndrome in his wrists?

A. Well, you said wrist, and it's unusual to develop bilateral --

Q. Wrists, plural.

A. Okay. It's unusual to develop bilateral carpal tunnel syndrome simultaneously, but usually one side is predominant. And looking at the pictures that he drew during that time interval, it sure looked like there was asymmetry.

Q. So your opinion was -- what was the cause of the bilateral wrists, plural, pain?

A. Diabetic peripheral neuropathy unless I see records that are to the contrary.

Q. An EMG was done of the upper extremities, right?

A. Correct.

Q. What did that find?

A. I'd have to look it up. I didn't commit everything to memory. But I do know where it is.

Okay. It does find bilateral median moderate neuropathy.

Q. Meaning?
A. That means that the median nerve is being compressed.
Q. Consistent with carpal tunnel syndrome?
A. Yes.
Q. And not consistent with DPNP in the wrist, correct?
A. Correct.
Q. And also the right lower extremity was examined in the EMG, and there were no positive findings, were there?
A. Right lower extremity -- no, there wasn't clinical correlation advised.
Q. So to be fair and to be accurate, the EMG that was performed in July about a month after the occurrence at Lowe's found consistent findings of carpal tunnel syndrome in the bilateral wrists and no consistent findings of DPNP in the right lower extremity; is that correct?
A. No polyneuropathy in the lower extremity.
Q. So what I said, is that correct?
A. Well, I just clarified it a little bit, so I stick with what I said.
Q. Well, would DPNP be evidenced by

polyneuropathy in the lower extremity?
A. It would be one sign of it, yes.
Q. So the EMG that was done of Mr. Narsimhan's right lower extremity of July 26, 2016, was not consistent with DPNP in the right lower extremity; is that correct?
A. Correct.
Q. You also said -- and if I understand what you said -- and I believe I heard what you said -- the way DPNP forms is when diabetes becomes out of control; is that right?
A. Correct.
Q. Can you explain to me, when you say "out of control," exactly what you mean by that?
A. What I mean by that is that you have elevated blood sugars chronically.
Q. You said elevated blood sugars, chronic something, and I didn't hear the rest.
A. Chronically.
Q. Chronically?
A. Yeah.
Q. Anything else?
A. That's what diabetes out of control is.
Q. Okay. And the way to test for elevated blood

sugars is an A1C test; is that right?
A. Hemoglobin A1C.
Q. Yes?
A. Yes.
Q. And I think this was discussed in Dr. Matiwala's deposition that if an A1C level was over 7, it means that the diabetes can become out of control, but under 7 the diabetes is in control. Do you remember him saying that?
A. Yes.
Q. Do you agree with that, that's accurate?
A. People draw the line at different places, but I think that's a reasonable place to draw the line.
Q. And I believe in Dr. Matiwala's records, you reviewed all of his A1C recordings?
A. Yes.
Q. So prior to the incident in Lowe's, we have at least I guess two visits to Dr. Matiwala. You saw that, right, in the records?
A. Matiwala.
Q. Matiwala.
A. Yes.
Q. You saw in the records that there was a visit of February 2016 and May 31st of 2016 prior to the

incident at Lowe's, correct?
A. Correct.
Q. And then there was a visit with Dr. Matiwala in September of 2016 that's after the incident at Lowe's, correct?
A. Right.
Q. You saw that initially the A1C in February of 2016 was 8.5, and you consider that essentially out of control, correct?
A. That's correct.
Q. And then the next visit of May 31st, 2016, so a little less than a month before our incident of June 25th, 2016, the A1C level was 6.6. Would you consider that A1C level an indication of under control diabetes?
A. That's borderline under control.
Q. It's under 7, so therefore it's within the in-control level?
A. It's high under control.
Q. What would you consider high then?
A. What I'm saying -- you know, if it's 0.5 higher, you would say it's out of control. So it's borderline. That's what it is.
Q. Would you agree that -- in your opinion,

would you think that a person who has a 6.6 A1C would be at risk for having diabetic peripheral neuropathy with pain, DPNP?
A. If they maintain that, no.
Q. September of 2016 the A1C level was 6.7, so point one higher. Would that person at that time be susceptible or at risk for DPNP?
A. Marginally. Likely not, but not impossible.
Q. So what was it about the A1C levels in May and September of 2016 that indicate to you that as of June 25th, 2016, Mr. Narsimhan was complaining of right lower extremity diabetic neuropathy with pain?
A. Say again, please.
Q. What is it about the A1C levels of Mr. Narsimhan in May of 2016 at 6.6 and September of 2016 at 6.7 that indicate to you that after 6/25/2016 Mr. Narsimhan was complaining of DPNP in his right lower extremity?
A. Those particular ones would not necessarily suggest that he would get diabetic peripheral neuropathy, but he did have others previously that -- again, I pointed out that Dr. Matiwala pointed out that his insulin dosage had not changed for years, and that he needed -- I mean, he really needed dietary

counseling, and that he was not monitoring his glucose. Now, those two isolated ones I completely agree with you, Mr. Berman, likely would not put him at risk, but we really don't know what went on long before that. We don't really know so much about what happened subsequently as well.
Q. If a person who has diabetes, the diabetes gets out of control causing DPNP, can one of the treatments for that DPNP be getting diabetes within control?
A. It won't get the neuropathy better. It will prevent it from progressing.
Q. When did the DPNP symptoms start for Mr. Narsimhan?
A. I don't know.
Q. Dr. Matiwala testified that throughout his time treating Mr. Narsimhan that Mr. Narsimhan had type 2 diabetes mellitus without complications. Did you see that?
A. Yes.
Q. Would a complication of diabetes be this DPNP that we're discussing?
A. Yes.
Q. So according to Dr. Matiwala's records and

his deposition, Dr. Matiwala, the doctor who was treating Mr. Narsimhan for the diabetes, felt like the diabetes was without complication, therefore without DPNP, true?
A. Yes.
Q. And also, Dr. Matiwala performed diabetic foot exams. You saw that, right?
A. Yes.
Q. Is part of the reason why a doctor does diabetic foot exams is to try to see if there is any indication of DPNP or diabetic peripheral neuropathy?
A. No.
Q. Okay. So a diabetic foot exam, in your opinion, has nothing to do with finding whether a person has diabetic peripheral neuropathy in their feet?
A. Correct. I shouldn't say -- it's not the main reason they do it.
Q. But it can help to find -- strike that.
Diabetic foot exams can help find DPNP in a person's feet?
A. Correct. Just so you know, that's not the principal reason that that exam is done.
Q. It doesn't have to be the principal reason.

It can be an ancillary reason. Dr. Matiwala consistently performed diabetic foot exams and found them to be negative, and, in fact, in his deposition, Dr. Matiwala felt that based on the diabetic foot exams there was no indication of diabetic peripheral neuropathy in Mr. Narsimhan's right lower extremity. Did you see that?
A. I don't remember that.
Q. Would you disagree with that testimony if it was there?
A. Well, if the testimony is there, I wouldn't disagree with what his opinion is.
Q. Switching gears for just a moment.
I think you saw in the record -- correct me if I'm wrong, but I think you saw in the record that prior to the incident of June 25th, 2016, at Lowe's, Mr. Narsimhan was very active, ran on the treadmill, did 5Ks, that kind of thing. Did you see that?
A. Yes. According to him, yes.
Q. Is that something that if a person has diabetic peripheral neuropathy in their feet or foot that this would make running on the treadmill and performing 5Ks difficult to do?
A. Yes.

Q. So do you see any indication in the record prior to June 25th, 2016, that Mr. Narsimhan had diabetic peripheral neuropathy in his right lower extremity?
A. No.
Q. You saw in the record I believe that because of the pain and discomfort in Mr. Narsimhan's right lower extremity that he was less physically active, correct?
A. That's what he says, yes.
Q. Obviously pain in the lower extremity can cause people to be less active, run less, be on their feet less, walk less, that kind of thing, agree?
A. Yes.
Q. Dr. Matiwala was asked on page 41 of his deposition whether the symptoms of right lower leg burning pains, if he was able to eliminate those as diabetic complications, and he said yes, he would. Did you see that in the deposition?
A. Yes.
Q. Do you disagree with Dr. Matiwala, the doctor who was treating Mr. Narsimhan for his diabetes?
A. Hold on a second.
Q. It's page 40, line 23 to page 41, line 3. It

diabetes?
A. No.
Q. If Dr. Matiwala says that he was able to get the diabetes under control, yet you in your opinion testified that the diabetes was out of control which was what caused the DPNP; is that correct?
A. That it had not been under control.
Q. When was the diabetes not under control such that it caused the DPNP in Mr. Narsimhan's right lower extremity?
A. Say the question again, please.
Q. Yes. The question is when was the diabetes out of control such that it caused DPNP in Mr. Narsimhan's right lower extremity?
A. During the time before he started seeing Dr. Matiwala or at the beginning.
Q. We just went over this, Doctor. In the beginning when Mr. Narsimhan started seeing Dr. Matiwala in May and September, in those two visits it was under 7, the A1C was under 7. So that's an indication of the diabetes being in control; you agree with that, right?
A. I think when he first started seeing Dr. Matiwala, that the diabetes was above 7.

says, "Okay. And these symptoms that he's reporting on a consistent basis, were you able to eliminate those as diabetes complications?" Answer: "Yes, I would based on the EMG conduction study he'd undergone." Do you see that question and answer?
A. I do, yes.
Q. Do you disagree with Dr. Matiwala?
A. No.
Q. On page 45 of Dr. Matiwala's deposition, he was asked at line 10: "And throughout the time you were seeing Mr. Narsimhan, you were able to get his diabetes under control, correct?" Answer: "That is correct."
A. You said 45, 10. I'm on 45, 10. I don't see that. Oh, okay.
Q. Should I reread it?
A. Yes. Okay, yes.
Q. And the question was: "Throughout the time that you were seeing Mr. Narsimhan, were you able to get his diabetes under control, correct?" Answer: "That is correct." Do you see that?
A. Yes.
Q. Do you disagree with Dr. Matiwala, the doctor who was seeing and treating Mr. Narsimhan for his

Q. Yes. So are you saying that in February 2016 the diabetes was out of control such that it caused the DPNP to begin in the right lower extremity?
A. It put the patient at risk.
Q. So when was the diabetes out of control such that it actually caused, not put him at risk, but actually caused the DPNP to begin?
MS. HAY: Just object to asked and answered. If you want to answer again, Doctor, go ahead.
THE WITNESS: He was at risk in February of 2016.
BY MR. BERMAN:
Q. I know, Doctor, but you said, in your opinion, Mr. Narsimhan has DPNP in the right lower extremity; is that right?
A. Yes.
Q. When was the diabetes out of control such that it caused that to actually begin, the DPNP in the right lower extremity?
MS. HAY: Objection, asked and answered. You can answer again, Doctor.
THE WITNESS: I think he was set up for it in February '16.

BY MR. BERMAN:
Q. He was what?
A. A setup.
Q. Set up?
A. Yeah.
Q. But the DPNP didn't start in February 2016, did?
A. We don't know.
Q. You don't know?
A. Likely it did not.
Q. So do you know when the DPNP started?
A. No.
Q. The symptoms of DPNP?
MS. HAY: Objection, asked and answered three times.
BY MR. BERMAN:
Q. Doctor, is it accurate to say that diabetic peripheral neuropathy typically is seen bilaterally?
A. Yes.
Q. And in this case it's your opinion that the DPNP is exclusive to the right lower extremity of Mr. Narsimhan, correct?
A. Yes. Well, we don't know exclusively.
Q. What do you know?

A. That on his examination -- well, we know that nobody ever did an distracted examination on this gentleman who makes certain accusations that I know have significant discrepancy. And I did not see, Mr. Berman, one distracted examination on this man who complains of pain when you look at him and you touch him and he sees you, but he doesn't consistently complain of pain when you distract him.
Q. Which doctor indicated that Mr. Narsimhan does not complain of pain when you touch his right lower extremity when he's distracted?
A. Nobody ever did a distracted examination, which an expert in CRPS would always do.
Q. Because no one ever did that test, are you assuming that it would be negative for CRPS?
A. No, I'm only -- we're not talking for CRPS. We're talking for pain. We truly don't know what it would have shown. The only place there's a data point with a distracted exam is my exam where you were there.
Q. So are you assuming that because Dr. Farbman, Dr. Saeed, Dr. Buvanendran, Dr. Matiwala, all these doctors who didn't do a distracted exam for pain that it would have been negative when those doctors saw and

examined Mr. Narsimhan?
A. What I'm saying is that we really don't know what a distracted exam would have shown. That's all I can say. We know that my distracted exam showed inconsistency. They never did. And this is a guy who has a motivation to have pain or to describe pain.
Q. That's true for any plaintiff in the world, right?
A. It's true. Well, not all of them complain about pain. They complain about different things.
Q. Any plaintiff who is complaining of pain has a motivation to say they have pain because in your opinion they've got a case, right?
MS. HAY: I'm sorry. I didn't hear the end of that question, Steve. Can you repeat it?
MR. BERMAN: Because they have a case.
MS. HAY: Thank you.
THE WITNESS: Any patient that has a complaint of CRPS has motivation to demonstrate they have pain.
BY MR. BERMAN:
Q. You didn't diagnose secondary gain in Mr. Narsimhan's case, did you?
A. I don't like to go into secondary gain. I

just see marked discrepancy here.
Q. I'm just asking, did you make the diagnosis or not?
A. What do you mean?
Q. Did you make a diagnosis of secondary gain in Mr. Narsimhan --
A. I don't make a diagnosis of secondary gain. I don't make it.
Q. Let's talk about your examination of Mr. Narsimhan, and that would be relating to the report of 1/21. Do you have the report in front of you, or do you want me to put it on the screen?
A. I can put it up very quickly so I can have it in front of me.
Okay. We are talking about the independent medical examination performed on 1/15/21; that's what we're talking about at the moment, correct?
Q. We're talking about the examination 1/15/21 that you performed in Chicago near O'Hare.
A. Yes.
Q. You called it an independent medical evaluation. I don't call it an independent medical evaluation because at that time you were retained by the defense to perform the examination, correct?

A. You can call it what you wish. I do it as an independent exam.
Q. I hear you. But at the time you examined Mr. Narsimhan, you had been retained by the party that Mr. Narsimhan had a claim against, right?
A. Right. And it's my job to do an objective exam, which is why I call it independent.
Q. But the answer to my yes is yes; is that correct?
A. The answer to that question is yes.
Q. And during that medical examination, you spent a total of about an hour with Mr. Narsimhan, correct?
A. Yes.
Q. You told Mr. Narsimhan at the time that you were retained by the other side; you told him that, right?
A. That I was retained by the defense, yes.
Q. And you told him that there was no physician-patient relationship generated from this examination; it was for medicolegal purposes only, correct?
A. Correct.
Q. During the examination, you took a history,

then you did an examination for symptoms and signs of potentially indicating CRPS, right?
A. Well, you don't do an examination for symptoms. You only do an examination for signs.
Q. So you did a history for symptoms, right?
A. Correct.
Q. You asked the patient -- you asked the client. I'm sorry. At the time of your examination, you asked my client what his symptoms were, right?
A. Correct.
Q. And then you performed an examination looking for the signs that might be related to CRPS, right?
A. Correct.
Q. And the signs can be objective signs, right?
A. The exam was the objective signs, correct.
Q. So things like swelling, the way the skin looks, hair changes, moisture, sweating, those are things that can be observed by the examiner, correct?
A. Correct.
Q. And those can be documented at times photographically, those signs, correct?
A. Excuse me? Say again.
Q. Some of those signs upon examination can be documented photographically because they're objective,

correct?
A. Correct.
Q. In your examination of Mr. Narsimhan, you took no pictures; is that correct?
A. That is correct.
Q. So to be fair, whether Mr. Narsimhan had any signs relating to a diagnosis of CRPS would not be documented one way or the other by use of photographs from your examination, true?
A. It could -- well, some of them are -- you can't diagnosis temperature with photographs. You can diagnosis tremor, hypertonia, spasticity with photographs. What you can diagnose with photographs are changes in the hair. Edema is hard because the way you diagnose edema is by looking for pitting, and you can't do pitting in a photograph. So what you can see are changes in the hair, skin, nails, or color changes.
Q. To be fair, Doctor, all I'm asking is, you took no pictures during your examination of Mr. Narsimhan to document the existence of or lack of signs relating to a diagnosis of CRPS, true?
MS. HAY: Objection, asked and answered. You can answer, Doctor.

THE WITNESS: Well, the only answer I give is that I did not take pictures, because I don't agree with what followed.
BY MR. BERMAN:
Q. In your examination of Mr. Narsimhan, it said, "Reflexes could not be performed at the ankle." Why is that?
A. Because of pain that he would have experienced based on what he was saying.
Q. That's related to the right ankle, correct?
A. Correct.
Q. The ankle is the one that's at issue in this case, correct?
A. Correct.
Q. Same with sharpness. It says, "Sharpness examination was deferred in the right leg, as mentioned above." That's because it would have caused significant pain in the right lower extremity, correct?
A. Because of what he said, yes.
Q. It says, "Calcaneal reflexes were deferred secondary to prevent pain." Same thing, correct?
A. Correct.
Q. That was only on the right side?

A. Correct.
Q. It says, "Dorsiflexion of the right foot was deferred." What does that mean?
A. It means that I didn't ask him to bend his foot toward the ceiling.
Q. And it says, "deferred." Why was that in this case?
A. Same thing, because he was complaining of pain.
Q. It was in the right affected leg as opposed to --
A. I was trying to avoid the pain. I didn't want to cause him any pain. And you were there, and you saw that I wasn't trying to cause him any pain or did I cause him any pain.
Q. I'm not accusing you of purposefully trying to cause him pain. I'm saying that -- I think you're agreeing with me that you deferred dorsiflexion of the right foot test because you felt that could cause him increased pain in his right affected lower extremity, correct?
A. If I recall correctly, I did ask him, and he said it was too painful to do, so we deferred it. So he never attempted it.

Q. And let's go to page 4 of your report where you talk about the requirements for CRPS. These are the Budapest requirements you're referring to specifically, right?
A. Yes.
Q. One was pain out of proportion for the original injury. It says, "Mr. Narsimhan endorses this." That means -- well, explain to me what you mean when you say, "Mr. Narsimhan endorses this."
A. Well, that's what he says, so I counted that as positive. When I do evaluations whether I am retained by the plaintiff or the defense, I don't always say that the plaintiff endorses it, but he endorsed it.
Q. Endorses means is positive in that requirement No. 1 is met?
A. I guess if you want to say it in more simple language, that's what he says. I mean, I think "endorses" is clear, but if you have trouble -- that's what he says.
Q. So requirement No. 1 of the Budapest test for CRPS is met, correct?
A. Right.
Q. Requirement No. 2 of the Budapest test for CRPS is, "Symptoms described by the patient from three out of the four designated diagnostic categories." Mr. Narsimhan endorses this as well, correct?
A. Correct.
Q. So requirement No. 2 for the Budapest test for CRPS is met, correct?
A. Correct.
Q. Requirement No. 3, that's the signs we were talking about upon examination. Two of the four designated categories is required to have been met. This one was not met, correct?
A. No. 3 was not fully met, right.
Q. So requirement No. 3 was not fully met because only one but not two of the criteria were met; is that accurate?
A. Categories.
Q. Categories. Accurate?
A. Yes.
Q. All right. So sensory was met after vasomotor, sudomotor/edema, motor/trophic, correct?
A. Correct.
Q. So the vasomotor are things such as -- let me check my notes, Doctor. Vasomotor are things like skin color changes, temperature differences, right?

A. Right.
Q. Sudomotor/edema are things like sweating or excessive sweating, correct?
A. Sweating, goose bumps.
Q. Motor/trophic changes are things like decreased range of motion, weakness, spasticity, tremor, dryness around the skin, right?
A. Well, a certain kind of dryness of the skin, but yes, it would be scaly skin.
Q. Scaly, okay.
You saw in Dr. Buvanendran's notes that he noted upon examination that Mr. Narsimhan had color changes to his right and left; you saw that, right?
A. Right and left?
Q. Yes.
A. Okay.
Q. I'm just asking about Dr. Buvanendran's records that I know you reviewed.
A. If it's right or left, it doesn't mean anything. Right and left, it doesn't mean anything to me.
Q. All right. Well, let's be clear then. Dr. Buvanendran noted in his records that there was a color change to the right lower extremity; there was

temperature difference between the right lower extremity and left lower extremity. Do you see that?
A. Well, I don't know what page you're on, which document.
Q. Dr. Buvanendran's records.
A. Why don't you put it up on the screen.
Q. I don't have it on the screen. Dr. Buvanendran's record -- it's also on page 49 and 50 of his deposition if you want to look it up, if you have access to that as well.
A. Well, I do.
Q. It says here there's change to the nailbeds. What is that considered? Is that a trophic change or sudomotor change, vasomotor?
A. It's not sudomotor.
Q. I'm sorry. Say that again.
A. It's not a sudomotor change. It could be a vasomotor change if it's described as such.
Q. So in Dr. Buvanendran's records and in his deposition on page 49 to 50, he describes on examination observing color change to the right lower extremity, temperature differential, and changes to the nailbeds in the right. Do you see that?
A. Trophic changes to the nailbed, yeah, he

does.
Q. So that would -- in terms of signs on examination, that would meet requirement three for the Budapest criteria, correct?
A. He met it on that date, yes.
Q. In terms of symptoms, Dr. Buvanendran noted hypersensitivity, the increased sweating, swollen, so edema. Those would be signs -- I'm sorry. My mistake. Those would be symptoms consistent with meeting requirement two of the Budapest -- let me back up, Doctor. I screwed that up entirely.
Dr. Buvanendran in his records and his deposition indicated that there were certain symptoms he elicited during his examination or his history of Mr. Narsimhan which included burning, stabbing pain in the right lower extremity, swollen right lower extremity, color change to the right lower extremity, hypersensitivity to the right lower extremity, and increased swelling in the right lower extremity. Do you see that?
A. Is that in his deposition or that's in his --
Q. In his records.
A. I'm looking at his record now. What date?
Q. The first date of examination.

A. 10/19, something like that?
I have 1/13/20, 2/14/20, 1/21/20. That's a follow-up.
Q. 7/30/19, try that one.
A. When?
Q. 7/30/19. Okay?
A. Okay, here, 7/30/19. Okay, I see it.
Q. Okay, there we go.
So in Dr. Buvanendran's record of his examination and history that he took of Mr. Narsimhan on 7/30/19, the requirement Nos. 2 and 3 of the Budapest criteria have been met, correct?
A. Yes.
Q. Requirement one would be met as well because that's ongoing pain that is disproportionate with the inciting event, correct?
A. According to this.
Q. And I think we talked about this earlier, so what I'm wondering is -- I think you said that signs relating to CRPS can wax and wane, and people can have good days and bad days with regard to those signs, right?
A. True.
Q. And do you know, maybe you don't know, but do

you recall that Mr. Narsimhan when he saw you, when you were asking him questions, he told you that today, when he was seeing you in the examination, was a much better day than usual? Do you recall that?
A. I don't vividly recall it, but I wouldn't say it didn't happen.
Q. So hypothetically, if Mr. Narsimhan was having a much better day on the day you saw him, which was January 15th, 2021, that means he may have less signs of CRPS than other days, correct?
A. That's true.
Q. Do you disagree with Dr. Buvanendran that when Dr. Buvanendran saw Mr. Narsimhan that Mr. Narsimhan met the requirements of CRPS?
A. I have an issue, but as documented on that visit, it would fulfill the diagnostic criteria for CRPS.
Q. So Dr. Buvanendran's examination and history and findings of Mr. Narsimhan would be consistent with fulfilling the Budapest criteria for CRPS. True so far?
A. Yeah, I mean, 7/30/19. Now, where I have issue with Dr. Buvanendran is --
Q. Before you give me your issue, answer the

question.
A. Okay. That exam as he documented would be consistent with meeting the Budapest criteria for diagnosis of CRPS.
Q. Now tell me your issue.
A. My issue is that all his exams have the exact same temperatures at the same places, have the same misspelling in words that he used like gauze, and it kind of -- it compromises the credibility of this whole situation if he's cutting and pasting. There are three exact exams on different dates where he has temperatures measured at 1.5 degrees to the calf; medial area, 2.5 degrees; 2.2 degrees at the foot. And I can tell you that way, way, way beyond medical probability that the temperatures -- three temperatures at three different places to be exactly the same on three different days is virtually impossible. Statistically way, way less than 1 percent. Within medical probability, within medical reason, within medical anything, you cannot have that, and here's a guy on three different occasions reporting the exact same thing. That's what I have an issue with.
Q. I understand that. Here's my question,

though, generally for you: Can a patient meet the Budapest criteria for CRPS on one examination, but then possibly not meet the Budapest criteria on the next examination --
A. Yes.
Q. -- or does it have to be -- okay.
A. I think I answered that question to you a few times already.
Q. Oh, good.
So as a treating doctor, if you have a patient who at times doesn't meet the Budapest criteria but had previously met the Budapest criteria, do you change the diagnosis?
A. Actually, what I say under those circumstances is that there are documented diagnoses of CRPS in the chart, and that on my exam it appeared that the CRPS is in remission if there were CRPS before based on credible examinations.
Q. That makes sense. But you say, "in remission," which does not change the diagnosis. It continues the diagnosis, but it's just the symptoms are in remission?
A. If they are credible exams, yes.
As a matter of fact, last week I did exactly

that on a plaintiff's exam.
Q. I'm certain that you reviewed Physical Therapist Schwartz's records and Physical Therapist Fischer's records, correct?
A. I don't know that I have Fischer's records. I reviewed Schwartz's records.
Q. You don't have Fischer's records?
A. I don't think I do.
Q. Maybe I'm mistaken. I thought you had them, but maybe not.
A. I think I told you at the beginning I didn't.
Q. I'm almost certain you told me you did not have his deposition. I know that for a fact. But I thought you had his records. Maybe that's where I was mistaken.
A. I don't recall the name Fischer as I was doing it. Do you know the facility where I could look for it?
Q. Yes, I think I do.
A. Hold on. I can do a search. Fisher, F-i-s-h-e-r?
Q. I have it, F-i-s-c-h-e-r.
A. Wait. We have to know for sure which way.
Q. F-i-s-c-h-e-r, Brian Fischer.

A. No items match the search.
Q. In your practice -- let me just ask you this way. I'm not worried about that at this time. I'm going to try to wrap up, if I can.
In your practice, at times do you prescribe physical therapy for patients with a diagnosis of CRPS?
A. Definitely.
Q. So physical therapy is one recognized method of treatment for CRPS, right?
A. It's one important component.
Q. Okay. And are there certain -- to your knowledge, are there certain physical therapists who seem to have more training in regards to treating CRPS patients than others?
A. For sure.
Q. Dr. Buvanendran, in fact, prescribed physical therapy for his patient Dr. Narsimhan. You saw that prescription, right?
A. You said Dr. Narsimhan. Is he a doctor?
Q. Did I mess up the question? I had it right for me. I don't know about you.
Dr. Buvanendran prescribed physical therapy to treat the right lower extremity symptoms in his

patient Mr. Narsimhan, right?
A. Yes.
Q. You don't have a problem with that prescription for that type of treatment for those symptoms, do you?
A. No. I'm very careful with how I prescribe it myself, but I don't know his infrastructure to be able to know if I like the way he prescribed it or not. But it's the right thing to do.
Q. And Physical Therapist Fischer -- let me back up. Physical Therapist Schwartz, who I know you did review her records and her deposition, indicated upon her initial examination of 1/13/20, she wrote down "53-year-old male who presents with signs and symptoms consistent with referring diagnosis." Do you see that?
A. Yes. Well, I don't see it.
Q. Well, referring diagnosis, but take out the words CRPS right lower extremity, right?
A. Here, I have Lisa Schwartz in front of me now.
Q. Take a look at 1/13/20. Its page 97 of the records if it helps at all.
A. Okay. So she says -- hold on. It looks like

I have 1/13/20, page 1 of 4, and then I don't have pages 2 of 4. I don't have pages 2 of 4, so I don't have what you're quoting.
Q. Do you have the diagnosis portion of that where it says "Outpatient Physical Therapy Initial Evaluation"?
A. Excuse me. I have page 1 of 4, which doesn't go down to that. Then pain location, pain range, and then it goes right into -- unfortunately, it goes into the exam of 2/14. So I only have one page of that. I have plaintiff's Bates page 94. Is that what you're looking at?
Q. No. No, I'm looking at the records themselves. Maybe you're missing them. But the initial evaluation by Lisa Schwartz was on 1/13/2020.
A. Which I have 1/13/2020. I have that.
Q. That's what I'm looking at.
A. I only have one page of it.
Q. Do you see on 1/13/2020 Lisa Schwartz's records show a diagnosis CRPS --
A. I don't think you're getting what I'm saying. She had four pages of notes. I only received one.
Q. I'm asking which one? Do you have a diagnosis on one page?

A. Page 1 of 4, the last thing is, "patient goes".
Q. So do you know what the patient, Mr. Narsimhan, was -- what diagnosis Mr. Narsimhan was referred to Lisa Schwartz to treat?
A. She says the diagnosis was made in 2019. Started with PT immediately after he had his first injections.
Q. So we don't know what the diagnosis was he was referred to her for?
A. Well, no. It said there was a diagnosis made in 2019.
Q. It says, "a diagnosis." What was the diagnosis?
A. No, it says, "diagnosis CRPS in 2019." You should be able to find that in the 1/13.
Q. All right. So Mr. Narsimhan presented to Lisa Schwartz for physical therapy on 1/13/2020 with a diagnosis of CRPS right lower extremity, agreed?
A. That's what Dr. Buvanendran sent him to her for.
Q. And the assessment that Lisa Schwartz stated in her records was "Patient is a 53-year-old male who presents with signs and symptoms consistent with

referring diagnosis."
A. Okay. Please read her physical examination to me because I don't have it.
Q. I'm just asking you if you've seen the assessment or not.
A. Well, I've told you that I only have page 1 of 4 of that. I've said it like three or four times.
Q. So you're telling me you don't have the assessment in that?
A. I keep telling you the same thing. Yes, I do not have the assessment. I only have Bates page 94, page 1 of 4 of Lisa Schwartz's 1/13/20 note, and I'm missing pages 2, 3, and 4. It didn't come to me on that PDF.
Q. Did you ever ask the attorney who sent you the records to give you more complete records for Ms. Schwartz?
A. I did not.
Q. If you're missing certain portions of the records, wouldn't that be relevant to your opinions?
A. It would.
Q. Then you're missing certain portions of Linda Schwartz's examination and assessments of her patient Mr. Narsimhan, right?

MS. HAY: I think it's Lisa Schwartz, by the way, Steve.
BY MR. BERMAN:
Q. Lisa Schwartz.
A. It is. It's Lisa Schwartz.
Q. With that caveat, can you answer my question?
A. The answer is, it would have been better if I had asked for those records, but I missed that in the plethora of records that I was reviewing.
Q. Let me switch gears. It is accurate you commonly don't see nerve damage visible in patients diagnosed with CRPS?
A. Can you repeat that, please?
Q. Is it accurate that you commonly don't see nerve damage visible in patients diagnosed with CRPS?
A. In CRPS 1.
Q. In CRPS 1, that's true?
A. That's true in CRPS 1.
Q. CRPS 2 is when there's actual damage to a nerve, correct?
A. Correct.
Q. You saw Dr. Saeed in her records and deposition that she came to the conclusion based upon her examinations of Mr. Narsimhan that her diagnosis

was CRPS right lower extremity, correct?
A. Right. And that was, in 7/7/18, two years --
Q. I know when it was. Just answer my question. That's okay.
A. I answered it.
Q. And you disagree with that diagnosis, right, by Dr. Saeed?
A. I'm having trouble finding that note, but I would like to -- do you have that note in front of you?
Q. Not that I can put on the screen. I have it in paper.
A. I have a webcam myself. I can give it to you.
She makes a possible diagnosis of CRPS at that time, and I guess my question is, why would that happen two years after the incident?
Q. My question is, Doctor, do you disagree with Dr. Saeed's diagnosis of CRPS right lower extremity?
A. I don't have the note in front of me at the moment, and I can't commit.
Q. You can't say whether you agree or disagree with Dr. Saeed?
A. Until I have the opportunity to review her

note, I cannot do that. There are just so many records here.
Q. What about Dr. Buvanendran, Dr. Buvanendran made a diagnosis of CRPS right lower extremity; you saw that in the records, right?
A. Yes.
Q. Do you disagree with Dr. Buvanendran's diagnosis of CRPS right lower extremity?
A. I believe in his multiple duplicated evaluations, that they did provide diagnostic criteria for CRPS. Asked and answered.
Q. No, I know that you said that there was diagnostic criteria present for CRPS in Dr. Buvanendran's records. I'm simply asking, as a medical professional based on your review of the records, do you disagree with Dr. Buvanendran's diagnosis of CRPS right lower extremity for Mr. Narsimhan?
A. What I'm saying -- and I think I keep -- I mean, I don't know how I can say it differently. That his documentation supports a diagnosis of CRPS in the multiple duplicated evaluations that he put in his chart.
Q. So you agree with Dr. Buvanendran's

diagnosis?
MS. HAY: I'm sorry. Can you read that -- I missed that question, Steve, or can Ms. Court Reporter read it back?
BY MR. BERMAN:
Q. Sure. I'm simply asking, can you tell me you agree or disagree with Dr. Buvanendran's diagnosis?
MS. HAY: Hold on one second, Doctor. I'll just object to asked and answered. I think he's answered it already, but you can go ahead and answer, Doctor.
THE WITNESS: Well, clearly, Mr. Berman, I was not present at that exam. And what I'm telling you, Mr. Berman, is that his documentation if done accurately, even though I raise the question how three consecutive examinations could have the exact same data in them, but if he is documenting accurately in his three duplicated exams, then they do fulfill the diagnostic criteria for CRPS. And not being there, I cannot go further in what I have to say.
BY MR. BERMAN:
Q. So as a medicolegal consultant in this case, you can't state an opinion of whether you agree or disagree with Dr. Buvanendran's diagnosis?

A. I'm going to say the same thing. I wasn't there. What I can tell you is that he provided adequate documentation in his duplicated examinations to provide a positive diagnosis utilizing the diagnostic criteria of Budapest -- of the International Association for the Study of Pain for the diagnosis of CRPS.

Q. I know, but you weren't there for any of these doctors who examined Mr. Narsimhan other than yourself.

A. Correct.

Q. So despite that, you're giving opinions about the diagnosis for Mr. Narsimhan's pain even though you weren't present at the examinations of Dr. Saeed, Dr. Buvanendran, Dr. Matiwala, Dr. Farbman, Physical Therapist Fischer, Physical Therapist Schwartz, right?

A. I don't have Physical Therapist Fischer's notes at all, and Physical Therapist Schwartz, I don't have the salient parts of her notes. And on the others, the only thing I can opine on is whether they met the diagnostic criteria based on their documentation.

Q. It is a fair characterization to say that the only thing you can really opine on is whether the

records accurately documented the diagnostic criteria for CRPS on any given date?

A. That's what I'm telling you.

Q. So Mr. Narsimhan may have had the diagnostic criteria for CRPS on dates other than the documented dates of Dr. Buvanendran, but it wasn't properly documented, that's possible, fair?

A. Well, that's flipping it the other way. And what that's saying is, maybe people did completely inadequate exams on other days, and that's why they didn't come up with the diagnosis of CRPS. I think that's what you're trying to say.

Q. Have you ever seen any doctors who maybe aren't as familiar with the Budapest criteria as you who perform examinations of patients, and then maybe don't document the Budapest criteria as carefully as you?

MS. HAY: Can you read that back, please? That was a long question.

(Whereupon, the record was read as requested.)

MS. HAY: I'm just going to object to form, foundation and vague and confusing. But if you understand, you can answer that, Doctor. Go ahead.

THE WITNESS: I'm going to answer it, Ms. Hay, the way I want to answer it. You may not like the answer.

At least what I'm gleaning from what you're saying, Mr. Berman, is do I see people that make a diagnosis of CRPS but did not provide adequate diagnostic criteria to establish that diagnosis, and clearly I see that all the time.

BY MR. BERMAN:

Q. And do you see the opposite as well, Doctor, you at times see doctors who fail to recognize CRPS because they don't perform the Budapest criteria examination?

A. Yes, I see that, too.

Q. Okay. And in this case, Mr. Narsimhan saw Dr. Farbman and Dr. Saeed, and I think in your opinion, the Budapest criteria was not properly documented, correct?

A. Nobody ever -- I mean, Dr. Farbman's account from what I gleaned from reading his notes and the way he does things -- it appears he may have retired. I don't know. I got that impression from the chart. But I got the impression he was a competent neurologist that were CRPS present he would have

picked it up.

Q. What gave you that impression?

A. Because a competent neurologist should be able to do that.

Q. You think any competent neurologist in the world should be able to do that?

A. Well, should and does are two different things, but if it's a competent neurologist, "should" fits.

Q. How do you -- what makes you think that Dr. Farbman is such a competent neurologist that he should be able to perform a Budapest criteria examination and document it properly?

A. Well, that's a whole different thing. That's different than what you asked me, sir. What you asked me is would he be competent to be able to make a diagnosis, and documenting it is another thing. But based on the way his notes are written -- and believe me, I see the broad spectrum of notes. And based on the quality of his notes, it's my opinion that he's a competent neurologist. Now, I'm not there at his own institution, but he's not at a shabby institution either. That in a good institution somebody who keeps good notes, who doesn't copy his notes from visit to

visit verbatim is a competent neurologist.

Q. Is there any other reason other than doesn't copy his notes from day to day that indicates that Dr. Farbman is a competent neurologist capable of understanding and performing and documenting the Budapest criteria, anything else?

MS. HAY: Just object to misstating his prior testimony about his review of his record, but you can go ahead and answer, Doctor.

THE WITNESS: And, Ms. Hay, thank you, because I was going to use nonlegal words to say he was twisting what I was saying.

And the bottom line is, I'm not saying that he was competent to document the diagnostic criteria for CRPS, but he's competent to be able to make a diagnosis even if he doesn't document it properly or at the minimum -- and this is really important -- at the minimum raise in his differential diagnosis, which any competent neurologist would do, would raise the possibility of CRPS if it was present, and he did not do that.

BY MR. BERMAN:

Q. What about Dr. Saeed, did you get the impression that she was a competent neurologist to

make a diagnosis of CRPS even if she doesn't document the Budapest criteria properly?

A. I think she is competent to raise the question of CRPS, which is what most of the neurologists in my community do. They don't fully establish a diagnosis. They raise it so that when they send the patient to me, I can actually opine as to whether it truly is or isn't. And I would say that that's a mixed bag about what comes back.

Q. Dr. Saeed raised the issue potentially of CRPS on her very first examination of Mr. Narsimhan on 7/17/2018. Did you see that?

A. That is correct, and I'm looking for that record. I'm having trouble finding it. But that date is indelled [sic] in my mind, engraved in my mind. So I remember that date. I remember seeing that. But I'm having trouble finding it to read it to remember whether or not she did appropriate documentation on that date.

Q. What does the word -- I saw a word in the records, Doctor, I don't understand. What is dysesthesias, d-y-s-e-s-t-h-e-s-i-a-s?

A. Could you repeat -- spell it again. Spell it more slowly, please.

Q. D-y-s-e-s-t-h-e-s-i-a-s.

A. Can you write it on a paper, and just put it --

MS. HAY: I think it's dysesthesias.

THE WITNESS: Oh, "D." I didn't hear the "D." Okay, I got it now. Linda helped me.

Dysesthesia means an abnormal sensation. Something feels differently than it's supposed to feel.

BY MR. BERMAN:

Q. Is that a potential indication of CRPS sensory criteria?

A. Not a big one unless you consider allodynia dysesthesia, which I don't. Dysesthesia could be feeling like ants are crawling on you, which is also a form of dysesthesia called formication. But it's like, if you touch somebody and it feels differently than what you're touching, or you just have different -- dys means not functioning properly, and esthesia means sensation. So sensations not working right is what dysesthesia is.

Q. Can that be a sensory -- can that relate to the sensory category of CRPS symptoms or signs?

A. Clinically, yes.

Q. What is claudication?

A. Claudication is essentially decreased blood flow to an area.

Q. Is claudication pain and burning pain?

A. No.

Q. No? What are the symptoms of claudication?

A. Feeling of ischemia.

Q. What does that mean?

A. What does that mean? Ischemia is decreased blood flow.

Q. What does decreased blood flow feel like to a patient?

A. Very unpleasant.

Q. Painful?

A. Yes.

Q. So claudication-like symptoms would be painful symptoms, right?

A. Yes.

Q. Very painful, right?

A. Caused by decreased blood flow.

Q. Well, claudication-like symptoms would be symptoms that are severely painful, correct?

A. Claudication is claudication. Claudication is basically too little blood flow to the muscles

during exercise is what claudication is.
Q. Is claudication a diagnosis?
A. Well, it's a sign or it's a symptom.
Q. The words "claudication-like symptom" would be describing the feeling a person has from claudication; wouldn't you agree?
A. I don't really understand the question.
Q. You know what claudication is?
A. Right.
Q. You know what claudication symptoms feel like, right?
A. Yeah, it's usually like a cramping of the muscles because -- okay. There are two kinds of claudication. There's vascular claudication. There's spinal claudication. And basically, you're walking down the street and your legs cramp up because they're not getting enough blood flow or that the spine is not providing enough positive input into the leg that the legs cramp up, and you can't walk anymore. That's what claudication is. So it's essentially a muscular kind of problem, not nerve kind of problem.
Q. But patients don't come to you and say, "Hey, Doctor, I'm feeling claudication today," do they?
A. That's -- I mean, is a patient going to come

to me and tell me they have paroxysmal atrial tachycardia or paroxysmal delancination. I mean, a patient doesn't come to me and tell they have claudication.
Q. Right. Patients comes in and tell you that they're feeling pain or burning pain, and doctors have to describe it in some way, right?
A. Right, okay.
Q. And a doctor may describe burning pain as claudication-like symptoms, right?
A. Are you testifying to that or making it up?
Q. Can you answer my question, Doctor?
A. Well, they wouldn't do that because it's wrong.
Q. I thought you said claudication-like symptoms would be painful. Is that wrong?
A. Yeah, okay. Hitting your hand with a hammer is painful and putting a soldering iron on your hand is painful, but they're not the same. And having muscular pain due to ischemia is very different than having burning nerve pain, and so they're not the same.
Q. So what does the muscular pain due to ischemia feel like?

A. Cramping. It's a severe dull ache.
Q. Severe dull ache, is that what you said?
A. It doesn't even have to be severe. Dull ache.
Q. It can be severe, though?
A. Can be severe.
Q. So claudication-like symptoms could be a severe dull ache, correct?
A. Correct, yeah.
Q. The only reason I'm asking you that is Dr. Farbman on 2/9/17 wrote down "claudication-like symptom." Do you know what he's referring to there?
A. Well, I mean, that could be ischemia caused by diabetic -- not peripheral neuropathy, but by sequelae of diabetes because that's very, very common in diabetes.
Q. Or it could just be he's describing a severe dull ache, right?
A. Well, you have to have a reason to have the dull ache.
Q. Going back to your medical examination. Relative to requirement No. 4, you said requirement No. 4 of the Budapest criteria was not met because there was another explanation for Mr. Narsimhan's

right lower extremity pain, and that was diabetic peripheral neuropathy with pain, correct?
A. Right, which it looks like on this occasion I would have to say that that's not accurate.
Q. What do you mean by that?
A. I mean, I have to withdraw No. 4 not being satisfied.
Q. So previously based on your report, your examination when you said requirement No. 4 was not satisfied, you're withdrawing that, and you're saying it was satisfied as of right now, right?
A. Correct.
Q. Understood.
I'm just looking at your report. I'm just going to wrap up here, just getting some report questions done.
In your report on page 5, your independent medical examination report which is Exhibit B-1, page 5, the sixth paragraph down.
A. Hold on. Okay, page 5.
Q. The sixth paragraph down where it says, "Mr. Narsimhan has diabetes mellitus" -- actually, I'm going to skip that and go down to the next paragraph, which is, "Mr. Narsimhan was not considered to have a

diagnosis of complex regional pain syndrome until three years after the incident." Do you see where you wrote that there?
A. It should have been two.
Q. It should have been two.
In your experience, I mean, in your clinic and in your work as a medicolegal examiner, is there some range of timing when CRPS gets actually diagnosed after a traumatic event?
A. Yes.
Q. What is that range?
A. It's usually within three months that the patient has unrelenting problems and seeks care to the point that they get care unless they don't have insurance. That's the only situation -- I would say that's pretty much the only situation when somebody has active CRPS that they don't start getting treated for CRPS in the first three months unless -- I mean, not in Chicago, okay, but if they were in the boonies somewhere, then it could happen. But like in LA, which is the same as Chicago for all intents and purposes as we're talking here today, if you have CRPS and you're at month three and things are bugging you, you're going to a doctor on a regular basis and

complaining about how bad it is. That's the natural course of CRPS.
Now, there are doctors that have a dull ear toe to that. And, you know, it may be gratuitous for me to be saying that here, but, you know, they still usually will write it down and then ignore it. But what we have here is a guy who's getting a lot of medical care, and he's just not behaving like a CRPS patient would behave saying, "We got to get rid of this. You know, you really got to treat me. I need something done about this." And we're just not seeing that, and that's the reality of the world I live in.
Q. In Mr. Narsimhan's case, within two months after his incident at Lowe's, so on August 2nd, 2016, he's prescribed a medication called Lyrica. Is Lyrica used for nerve pain, to treat nerve pain?
A. Yes.
Q. Can Lyrica be used at times to treat CRPS pain?
A. Yes.
Q. I know that obviously we talked about this. At some point the Lyrica was changed to Gabapentin. But at least you agree with me as of August 2nd, so within that three-month time frame after the incident

at Lowe's, Mr. Narsimhan is being prescribed Lyrica which potentially could be a treatment for CRPS pain, right?
MS. HAY: Objection, asked and answered. You can answer again, Doctor.
THE WITNESS: I'd say I haven't answered it for Lyrica. I answered it for Gabapentin. They're cousins, and either can be used. And neither is FDA approved for that purpose. And I don't think we separated out the hand neuropathic pain at that point from leg neuropathic pain, so I don't really know which he was prescribed for. Are you saying August of 2016?
BY MR. BERMAN:
Q. Yes, Doctor, 8/2/2016, August 2nd.
A. Is that Farbman?
Q. It is, Doctor.
A. Okay. Let me just pull it up.
I'm just looking for that. I have Dr. Saeed's notes in front of me now, which I couldn't find before. I think I have Farbman's notes. I'm having trouble finding Farbman's notes as we're speaking here.
MS. HAY: I don't know if -- they were under

Northwest Neurology, if that helps, Doctor.
THE WITNESS: Yeah, except the Northwest Neurology I'm pulling up right now is only pulling up Dr. Saeed's notes.
MS. HAY: I thought they were all in one bundle, but I think some of them might have been a little out of order.
Doctor, are your Northwest Neurology notes Bates stamped?
THE WITNESS: They're not Bates stamped.
BY MR. BERMAN:
Q. Doctor, for this reason -- at the very beginning of the deposition I asked you to put your file on a disc or in a drive somewhere and get it to defense counsel so they can get it to me. I'm asking you to get all your records, whatever you reviewed in relation to this case, put it all on one drive, and let me take a look at what you got. So I appreciate that. Thank you.
MS. HAY: I don't know if it will help you then, Doctor, but the August 2nd, 2016, note that I have is Bates stamped page 39 out of 58 pages total, if that's helps.
THE WITNESS: It doesn't look like -- I don't

know what happened, but it looks like it's missing. Oh, wait.
BY MR. BERMAN:
Q. Can we move on, Doctor?
A. Well, you want -- yeah, you can. I'm just having computer problems right now, but I think I found it. It looks like I found it. I'm sorry. It's just not easy to find right now. You can move on.
BY MR. BERMAN:
Q. I'm going to share my screen, and show you what's attached as Exhibit B to your deposition. And this is B-3. It's your three-page expert report.
A. Right.
Q. My question for you, Doctor, is this a document you typed or is this something that defense counsel typed and you signed?
A. No, this looks like my typing.
Q. So page 1 of Exhibit B-3 is, No. 1, Qualifications. That's all your qualifications. That's true for any expert report you do no matter what, right?
A. Correct.
Q. All right. So this --
A. No, that's not true. That's true for ones

that I do with regard to complex regional pain syndrome.
Q. So you use this page of qualifications for any report you do for complex regional pain syndrome?
A. Well, actually, I kind of create each individually, but this is the one I created as my qualifications for CRPS.
Q. Is this a cut-and-paste job for qualifications you've used before?
A. I don't believe so, no.
Q. And page 2 is your opinions, and it goes on to page 3, right?
A. Yes.
Q. And you would amend these opinions based upon your testimony today, right?
A. Excuse me?
Q. You would amend your opinions based upon your testimony today, right?
A. Correct.
MS. HAY: I'm sorry. You trailed off, Steve. Sorry.
MR. BERMAN: Judy, what did I say?
(Whereupon, the record was read as follows:

"Q. You would amend your opinions based upon your testimony today, right?
A. Correct.")
BY MR. BERMAN:
Q. Lastly, Doctor, I know we went over your examination. I'm going a little bit further. One thing I wanted to ask you relative to your examination of January 15th, 2021, had you upon examination found one additional sign of CRPS in the vasomotor, sudomotor, or even motor/trophic, the Budapest criteria would have been met, and the diagnosis would have actually been CRPS, correct?
MS. HAY: I'm sorry. Steve, you're just getting distorted. Ms. Court Reporter, did you hear that?
(Whereupon, the record was read as requested.)
MS. HAY: Did you hear and understand that, Doctor?
THE WITNESS: I did, and I answered it twice. Yes.
MR. BERMAN: I'm sorry, Doctor, it's been so long. We're over three hours. I have no further

questions at this time.
THE WITNESS: I thought it was going for four hours.
MR. BERMAN: Do you want me go another hour, Doctor?
MS. HAY: I've got some questions.
THE COURT REPORTER: Could I just take two minutes?
MS. HAY: Sure.
(Whereupon, a short break was taken, after which the following proceedings were had:)
EXAMINATION
BY MS. HAY:
Q. Doctor, the report that you prepared with regard to this matter that outlines your qualifications, as well as your opinions, are those all opinions that you hold to a reasonable degree of medical certainty?
A. They're not all of them, no.
Q. Are the ones that are listed here in that report, are those your -- are those opinions all to a reasonable degree of medical certainty, though?

A. Wait.
MR. BERMAN: Which report?
MS. HAY: His expert report.
THE WITNESS: So I have to break the question -- I'm not trying to be -- I am a little punctilious here. But why don't you ask the first question -- oh, the first one was, were they all my opinions; is that correct?
BY MS. HAY:
Q. Let me restate it, Doctor. In your expert report where you lay out your opinions -- do you have that in front of you?
A. No, but I can get it.
MR. BERMAN: Exhibit B-3.
THE WITNESS: You want to just put it on the screen. It will be easier than me finding it and save us some time.
MR. BERMAN: I can do it quickly.
MS. HAY: If you can do it quickly because I'm on my iPad.
THE WITNESS: Okay, there it is. Yes.
BY MS. HAY:
Q. Doctor, are these all of your opinions to a reasonable degree of medical certainty?

A. They are not.
Q. Can you tell me are there -- what's the reason for that?
A. The reason for that is that there are different -- there are additional records that have been provided to me since then, and they have allowed me to form other opinions.
Q. Doctor, can you just be a little more clear for me with regard to which opinions are different?
A. Well, they're not different. You just said they're additional.
Q. Which are the -- can you tell me what additional opinions you have?
A. Yes. I have an opinion that there's a marked discrepancy between the way I conducted the exam on 1/15/21 than the way Dr. Patel documented the way that Mr. Narsimhan said I did it, and we could go into greater detail. But what I can tell you is that there was an intervening exam performed a month later which was a month before Dr. Patel's exam, and in that exam there was no mention of an exacerbation occurring as a result of -- I don't know what words to use -- hold on. I'll get you the exact words so you have it. In which Mr. Buvanendran indicated that his right --

Q. Excuse me. You mean Mr. Narsimhan?
A. Yes, sorry. I misspoke.
Mr. Narsimhan claims that his right leg was handled in a rough manner in which a flare of his CRPS -- which prompted a flare of his CRPS. Now, very interesting that the same gentleman who reported that to Dr. Patel on -- in March of 2021, did not report that at an intervening examination in any way that he had a flare or that he had his limb handled in a rough manner. And what I can say is, number one, in that regard as somebody who's an expert in CRPS, I'm exquisitely sensitive to the fact that CRPS patients can have bad reactions to what is done. And so I am extra careful in my medical practice in avoiding anything that could traumatize a patient. Now, that's in my medical practice.
In my medicolegal practice, especially when I am evaluating on behalf of defense, I am extraordinarily cognizant of that, and even more careful than I am in my clinical practice. And what I can tell you based on what my written documentation that was done before this accusation is that I indicated on every occasion that I deferred a part of an examination because of his complaints of pain, and

it's really incredulous to me with Mr. Berman present who would have stopped me if I was doing anything painful to his client, with my special care to do that, with him not complaining about it a month later that he would then at a plaintiff's expert examination then come up with this accusation is patently not true.
Q. Doctor, as far as the record that you relied upon where that suggestion or outright statement was made, was that to your understanding made in an accounting when he went to Rush Pain Clinic on March 2nd, 2021, and made that complaint to Dr. Patel, a fellow in Dr. Buvanendran's office?
A. Yes.
Q. Was there any indication -- so your independent medical exam was on January 15th of 2021, correct?
A. Correct.
Q. And this complaint then that Mr. Narsimhan made about your rough handling of him was made about two months later, fair?
A. Correct.
Q. And was there any indication that you saw in any of the records that you were provided surrounding

Dr. Patel/Buvanendran's evaluation on March 2nd that Mr. Narsimhan had contacted any of those doctors at Rush prior to March 2nd but after your examination?

A. No.

Q. Within that time period, Doctor -- well, one other question about that. Was it your understanding as well that Mr. Narsimhan on March 2nd for the first time told Dr. Patel and/or Dr. Buvanendran that as a result of your rough handling he had a "flare" of his condition in his lower extremity?

A. That's what I just read.

Q. And was it your understanding that at that evaluation as well he now complained that he had had some more significant complaints now to his left lower extremity?

A. Yes.

Q. And that complaint -- I'm looking at the wording in that report, and it says, "Now he has left leg burning pain in dorsum of foot, slow nail growth, no hair growth. He continues to work." And that's in the third paragraph under history and physical?

A. Yes.

Q. Within that time period, was it your understanding also, Doctor, that in February of 2021

that Mr. Narsimhan saw the plaintiff's retained expert for an independent medical exam, Dr. Joshi?

A. Wait. On what day?

Q. In February of 2021, a month after your examination.

A. Yes.

Q. And I believe the date of that was February 19th, 2021. Does that sound about right to you?

A. Yes.

Q. Was there anything you recall reading in either the report of Dr. Joshi's independent medical exam or Dr. Joshi's deposition where he indicated that Mr. Narsimhan complained to you that you were rough in your treatment of him in your exam?

A. No.

Q. Was there any indication that you recall reviewing in either Dr. Joshi's examination, report, or in his deposition that Mr. Narsimhan had a flare after your evaluation on January 15th?

A. No. And just to point out, Ms. Hay, to be fair to all of us, Dr. Joshi did not have his deposition taken until April, so that what occurred in February should have -- he should have commented upon

it in his deposition should it have occurred, should it have been reported to him as the expert.

Q. With regard to Dr. Joshi, is it your understanding that Dr. Joshi -- well, strike that.

Do you believe that your qualifications with regard to this particular case exceed those of Dr. Joshi as it may apply to either your treatment of CRPS patients or your experience, education, and training in the area of diabetes?

A. Well, first, I mean, I want to say in fairness to Dr. Joshi, I believe he's a qualified physician. He's a qualified pain physician. So I don't want to underrate him in any regard, and I always have respect for board-certified physicians. He's a board-certified pain physician. But there are two things that you bring up in your question that really need to be addressed. And the first one is, do I have more qualifications in CRPS, and I think Dr. Joshi would not dispute that I do. I mean, it's what I do for a living. It's 80 percent of my new patients, and I've been doing it for 25 years. And I believe I have more qualifications in CRPS than he does without trying to diminish him in any other way.

With regard to the second question that you

asked, I am a board-certified internist having taken care of medical patients for a significant portion of my career, having completed an internal medicine residency, and as a result I have experience in dealing with obese, diabetic patients.

Q. Doctor, with regard to -- well, strike that.

As to the Budapest criteria, Doctor, do you feel you are well qualified to apply the Budapest criteria?

A. Yes.

Q. Is it important to you, Doctor, in applying the Budapest criteria that there are precise measurements and assessments that are done with regard to the various categories that need to be assessed?

A. Yes. I wanted to point out one other thing that I wasn't given the opportunity to say, which is, in Dr. Patel's note that was signed by Dr. Buvanendran, we also, once again, have the identical physical examination that has gone through the record from visit to visit to visit. So I think it is very safe to say that given that that examination was pasted from other examinations that we really do not know what the examination was on that day.

Q. Doctor, on page 27 of Dr. Buvanendran's deposition, he was asked this question and answer, and I'm going to read it for you and ask if this is consistent with your comments with regard to the records of Dr. Buvanendran through some of his visits. And for the record, I'm reading on page -- starting on page 26 and continuing on to page 27. The question is, "And, in fact, the entire examination section that you've written, down to the punctuation is exactly the same as the prior visit. Is it unusual that your examination of the patient three months later is exactly the same?" Answer: "No, it's not. You asked" -- and then there's some objections.
Dr. Buvanendran continues in answer: "You know, when I see a patient and make a diagnosis, we don't -- it's part of an electronic medical record. The records are carried over from the previous time. But the fact is I do examine the patients every time, and if there are similar findings, I don't go correct everything. It's just this auto populates the facts. So it is very similar whether it's 2.2 or 2.1. It's not a huge deal to me. I'm treating patient -- a patient here. I'm not treating numbers or doing legal stuff. So I'm trying to treat the patient, and you want to be able

to provide appropriate medical care once you know what the diagnosis is. You don't need to be documenting every time you see a patient." And I don't think the last sentence really applies.
Does that support, Doctor, your comments with regard to some of the credibility issues about Dr. Buvanendran's findings in his notes?

A. Well, before I answer that, I just want to tell you, Ms. Hay, that I had one of my trainees copy a note from one visit to the next, and I warned him that if he did it again he wouldn't be working with me. That I feel extremely strongly, and it is -- it's not just me. It is the standard of care that what you do on a specific day is what happened on a specific day. And to copy something from another day is -- I mean, sometimes they copy from other doctors, and essentially that's plagiarism. But here he copied from himself, and whether he cares about the numbers or doesn't care about the numbers, he shouldn't be documenting numbers from another occasion because that's not what happened on that day, and it's misleading. And it is below the standard of care, very clearly, Ms. Hay, it is below the standard of care to copy a note from one day and put it in another

day.
Now, there a lot of things that don't change that are self-populated like all the medications the patient is taking, what the prior history is. But the exam on that day is something that happens on that day, and there is no freedom, absolutely no freedom to copy the exam from a different day into that day. And I don't think I can be any more clear on that.

Q. Doctor, is it your opinion to a reasonable degree of medical certainty that Mr. Narsimhan does not fit the diagnosis for CRPS?

A. Based on my examination, yes.

Q. You were asked some questions with regard to Dr. Matiwala's assessment of Mr. Narsimhan's diabetic condition, and I know you talked a little bit about his diabetic condition prior to the event at Lowe's. Was it your understanding that in accord with Dr. Matiwala's comment that an AIC over 7 or above would not indicate a good control of a diabetic; that there were AIC numbers that Dr. Matiwala recorded after the Lowe's event that were indeed 7 and above?

A. It's not AIC. It's A1C.

Q. I'm sorry. A1C.

A. Sorry. I'm not being fussy.

Q. That's okay. Thank you.

A. I am not recalling others. I don't want to say one way or the other where I saw them or not, but I don't want to swear to the fact that I saw other numbers over 7 in Dr. Matiwala's notes. But I certainly wouldn't rule that out. I have to swear that I can't remember.

Q. That's okay. If you don't remember, Doctor, that's fine.
With Dr. Matiwala's records, whatever the A1C numbers are in his records after the event you would agree would be numbers we could rely upon, fair?

A. Exactly and fully fair.

Q. Doctor, we were recently provided with, and I provided you with some photographs that were taken of apparently Mr. Narsimhan's feet. Do you recall getting those photographs?

A. Yes. I can pull them up because I do know exactly where those are.
Okay, I got them.

Q. And, Doctor, it's our understanding that these photographs -- I'm not sure if you had the actual dates, but on representation by Mr. Berman, and he can correct me if I'm wrong, these photographs were

taken by either Mr. Narsimhan or his wife and were taken I believe the first -- it might be tough to pinpoint the actual dates. But the first two were taken in I believe about August 2019 and the remainder in the later half of 2020.

MR. BERMAN: For the record, I did provide counsel with the exact dates the pictures were taken, if you recall.

MS. HAY: That's correct, you did, Counsel. But I think that's about the range that we were talking about generally speaking.

BY MS. HAY:

Q. With regard to those photos, Doctor, does anything in these photos change your opinion that Mr. Narsimhan does not have CRPS?

A. There is only one out of all those photographs, which is the next-to-last photograph that there's a comparison where there appears to be any kind of difference, and that difference is predominantly scaling that we could explain a variety of ways, including not washing your foot. And so all the others -- I could comment on each one individually why they don't mean anything to me. And on this fifth one, we would use basically requirement four if it

were showing up on that day to say that the only thing that looks different is the scaling, and that that scaling -- you know, the color -- likely looking at the other pictures, his one foot has more exposure to the sun than the other one. That's where I would explain the pigmenting in the first picture between the two feet. CRPS pain looks like -- the sign looks like a sun exposure sign. And in this one, which is the next-to-the one, that's not usually what you see as a CRPS skin change anyway, but if you want to call it that. We don't know what circumstances happened. For all we know, that's wet talcum powder on the foot. I don't know. I'm not there. I can't smell it; I can't feel it; and I can't say it means anything anyway.

Q. With regard to CRPS, Doctor, I know you indicated that patients can have some good days and some bad days, right?

A. Correct.

Q. We know, though, that Mr. Narsimhan specifically described what he told Dr. Patel apparently was a flare after your IME, fair?

A. Fair.

Q. Was there any indication in any of the

records or anything that you've seen that would indicate that Mr. Narsimhan during the course of some flare took any specific photos of his feet during the time of that flare?

A. No.

Q. Is there any indication through any of the other -- of the numerous medical providers that he's seen that would suggest to you that they took any photographs of his feet to confirm how his feet may appear differently by way of a photograph?

A. Well, the answer to the question is there are none. And not to be gratuitous here, but the more important thing is there's no complaints as documented telephonic notes or physician visits that demonstrate that any of that ever occurred.

Q. Doctor, other than the additional opinion that you talked about in light of Dr. Patel's report and we've talked about the photograph, have we essentially covered the bulk of your core opinions in this case with regard to Mr. Narsimhan?

A. Yes. I would just, Ms. Hay, acknowledge that based on the review that Mr. Berman pointed out that the likelihood of diabetic peripheral neuropathy is somewhat decreased, but my most important opinion in

this case is that there is not adequate documentation between 2016 and 2018 of CRPS. And hypothetically, even if we accepted a diagnosis of CRPS on 1/15/21, there is no way you could make a causal link between what happened in 2016 and what happened in 2018. Because, as I pointed out to Mr. Berman, if there was active CRPS between 2016 and 2018, the person active in the medical system would have complained about what he complained about, and then the Wheaton Chiropractic records where he himself filled out a form where he indicated hand pain but didn't indicate foot pain or leg pain is more evidence that nothing was bothering -- that the foot was not a CRPS kind of foot or leg or not CRPS issues at that time and during the succeeding three months where there was never any mention of the foot or the leg as sufficient information to indicate that between 2016 and 2018 that there was no CRPS whether or not we hypothetically accept that there was a diagnosis.

Q. But your opinion as you sit here today is that he does not have CRPS based upon all of the information that you've reviewed, your examination, your report, as well as your education, training, and experience; is that correct?

A. Based on my examination, that is true.
Q. And I take it, Doctor, given that you've talked about pretty extensively the nature of your practice with many CRPS patients that you diagnose and do treat that you're familiar with the chronology overall of how CRPS would proceed, and during that time frame, it didn't proceed according to that typical chronology; would that be fair?
A. Yeah, I think that just repeated what I said.
MS. HAY: Thanks, Doctor. That's all I have.
THE WITNESS: Wait. I have one other thing that I don't know whether it was put in there or not. But there clearly is a standard of care for a CRPS patient, and that is comprehensive interdisciplinary functional rehabilitation. That's a whole bunch of long words, and I could -- if Mr. Berman wishes me, I could go into more detail about what that is. But the bottom line is, Dr. Buvanendran, I expressed a very good opinion of him and said he's well respected. At the same time, as somebody who has the knowledge of CRPS, he should know that that is the gold standard for care. Dr. Joshi claims to be an expert in CRPS, and neither Dr. Joshi nor Dr. Buvanendran ever recommended the gold standard for care.

I mean, we start talking about possibly doing dorsal root ganglion stimulation, which is in Michael Stanton-Hicks -- I think I mentioned him, Mr. Berman, from the article. And in it he said failure to progress with conservative therapy -- which is the comprehensive program that I was talking about called FRP for functional rehabilitation program. Failure to progress with that is an indication to move toward interventional therapy. But until you try FRP, you cannot say the patient is appropriately being treated, and we don't know -- again, hypothetically, if we accept their diagnoses of CRPS, then he long ago should have been involved in functional rehabilitation to get him to a state where he wouldn't be complaining of what he's complaining about. He wouldn't complain that he was manhandled when he wasn't.
So it's very important that this was left out by people who claimed to know about CRPS. They didn't treat him like a CRPS patient. And the question that I would ask is, if they truly believe he has CRPS, why wouldn't they treat him like a CRPS patient?
BY MS. HAY:
Q. Would it be fair to say then, Doctor, that despite other treaters' diagnoses of CRPS their

actions with regard to treatment recommendations were inconsistent with that finding?
A. Yes.
Q. And are those your opinions, Doctor, to a reasonable degree of medical certainty as well?
A. Yes.
MS. HAY: That's all I have. Thank you.
FURTHER EXAMINATION
BY MR. BERMAN:
Q. I just have a couple follow-up just real quickly.
A. Thank you, Mr. Berman.
Q. During your examination of Mr. Narsimhan when you were actually physically examining him, doing your physical examination, your hands were shaking, Doctor. Can you tell us why that is?
A. Yes. I have a tremor from hypoglycemia, and I didn't have lunch that day. Normally, just so you know, when I do surgery and I don't have breakfast, I take a medication that makes that tremor go away.
Q. That's fine.
And two other things. After your examination, Doctor, of Mr. Narsimhan, did you watch him walk down the hall after he left the room where

you performed the examination?
A. I did.
Q. You watched him walk down the hall?
A. I believe I did, yes.
Q. You're saying you opened the door, you looked out the door, and was watching him go down the hallway? I was there, Doctor.
A. Right. And I'm trying to remember because -- I did two very similar situations, and I'm just trying to remember if this was the one or the other one was the one. But I think it may have been the other one. And so, I mean, on one of them, I watched the guy walk down the hall, and there was no limp whatsoever. I can't swear to it that this was the one of those two, because they were both in reasonable temporal proximity to each other that I did very similar kind of exams.
Q. I can tell you this, because we looked back after as we're walking down the hall, we didn't see you poking your head out the door. So fair to say that you can't recall observing Mr. Narsimhan walk from the door of the hotel room where the examination was performed down to the elevator; is that fair?
A. I thought I did, but I don't want to swear to

it.

Q. Did you watch Mr. Narsimhan go from the hotel into the car?

A. No.

Q. So as far as you can recall, your only interaction and observations of Mr. Narsimhan were within the hotel room where the medical examination was performed, correct?

A. Correct.

MR. BERMAN: That's all the question I have.

MS. HAY: Thanks, Doctor. I don't have anything further. We'll reserve signature.

(Witness excused at 6:57 p.m.)

IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF ILLINOIS
EASTERN DIVISION

KRISHNA NARSIMHAN,)
)
Plaintiff,)
)
-vs-) Case No. 1:19-cv-01255
)
LOWE'S HOME CENTERS, LLC,)
)
Defendant.)

I, JOSHUA P. PRAGER, M.D., being first duly sworn, on oath, say that I am the deponent in the aforesaid deposition, that I have read the foregoing transcript of my deposition taken 21st day of June, 2021, consisting of Pages 1 through 160 inclusive, taken at the aforesaid time and place and that the foregoing is a true and correct transcript of my testimony so given.

_____ Corrections have been submitted
_____ No corrections have been submitted

_____
JOSHUA P. PRAGER, M.D., Deponent

SUBSCRIBED AND SWORN TO
before me this _____ day
of _____ A.D., 2021.

_____
Notary Public

STATE OF ILLINOIS)
) SS:
COUNTY OF COOK)

I, Judith T. Lepore, Certified Shorthand Reporter in the State of Illinois, do hereby certify that on the 21st day of June, 2021, the deposition of the witness, JOSHUA P. PRAGER, M.D., called by the Plaintiff, was taken before me via videoconference, reported stenographically and was thereafter reduced to typewriting through computer-aided transcription.

The said witness, JOSHUA P. PRAGER, M.D., was first duly sworn to tell the truth, the whole truth, and nothing but the truth, and was then examined upon oral interrogatories.

I further certify that the foregoing is a true, accurate and complete record of the questions asked of and answers made by the said witness, at the time and place hereinabove referred to.

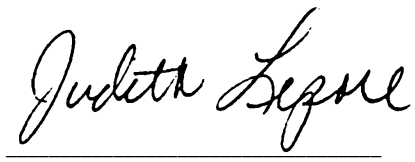
The signature of the witness was not waived by agreement.

Pursuant to Rule 30(e) of the Federal Rules of Civil Procedure for the United States District Courts, if deponent fails to read and sign this deposition transcript within 30 days or make other

arrangements for reading and signing thereof, this deposition transcript may be used as fully as though signed, and the instant certificate will then evidence such failure to read and sign this deposition transcript as the reason for signature being waived.

The undersigned is not interested in the within case, nor of kin or counsel to any of the parties.

IN TESTIMONY WHEREOF: I have hereunto set my verified digital signature this 8th day of July, 2021.



_____
Judith T. Lepore, CSR

License No. 084-004040

McCorkle Litigation Services, Inc.
200 N. Lasalle Street, Suite 770
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July 8, 2021
LINDA HAY, ESQ.
HEPLER BROOM LLC
30 North LaSalle Street
Suite 2900
Chicago, Illinois 60602
IN RE: Krishna Narsimhan v Lowe's Home Centers
COURT NUMBER: 1:19-cv-01255
DATE TAKEN: June 21, 2021
DEPONENT: Joshua P. Prager, M.D.

Dear Ms. Hay:

Enclosed is the deposition transcript for the aforementioned deponent in the above-entitled cause. Also enclosed are additional signature pages, if applicable, and errata sheets. Per your agreement to secure signature, please submit the transcript to the deponent for review and signature. All changes or corrections must be made on the errata sheets, not on the transcript itself. All errata sheets should be signed and all signature pages need to be signed and notarized.
After the deponent has completed the above, please return all signature pages and errata sheets to me at the above address, and I will handle distribution to the respective parties. If you have any questions, please call me at the phone number below.

Sincerely,
Cindy Alicea
Signature Department

Judith Lepore
Court Reporter
(312) 263-0052

cc: S. Berman

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IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF ILLINOIS
EASTERN DIVISION

KRISHNA NARSIMHAN,)
)
Plaintiff,)
-vs-) No. 1:19-cv-012556
LOWE'S HOME CENTERS, LLC,)
Defendant.)

PART II of the deposition of JOSHUA PRAGER, M.D., M.S., called for examination pursuant to the Rules of Civil Procedure for the United States District Courts pertaining to the taking of depositions, taken before MARGARET A. RITACCO, a notary public within and for the County of Cook and State of Illinois, on the 7th day of October, 2021, via Zoom, at the hour of 10:30 a.m.

Reported by: MARGARET A. RITACCO, CSR
License No.: 084-002796

APPEARANCES:

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Representing Lowe's Home Centers, LLC.

ALSO PRESENT:
MR. RYAN CHANCELLOR

I N D E X

E X H I B I T S

NUMBER IDENTIFICATION
(NO EXHIBITS WERE MARKED.)

THE REPORTER: My name is Margaret Ritacco, CSR. This deposition is being taken pursuant to Governor Pritzker's Executive Order 2020-14. All parties to this proceeding, including the court reporter, are attending via videoconference.
Will the parties please introduce yourselves, state who you represent, and that you are in agreement with these procedures, starting with plaintiff's counsel.
MR. BERMAN: Steven Berman, I agree.
MS. HAY: Linda Hay, for the defendants. We agree. And also on the call today is Attorney Ryan Chancellor from my office to observe.
MR. BERMAN: And for the record --
THE REPORTER: Doctor, will you -- oh, sorry. Go ahead, Steve.
MR. BERMAN: Before we do anything further, for the record, this is part two of a deposition. The last Deposition went 161 pages with all -- at the very, very end, and so this should be a continuation of that. All right?
I don't think you need to re-swear in the witness, but if you want to, that's fine. I mean, I -- it's up to you. I think he's already --

EXHIBIT B

since it's a continuation, I don't think it's necessary. But I know -- if you want to go ahead and do that anyway.

(Witness sworn.)

JOSHUA PRAGER, M.D., M.S.,

called as a witness herein, having been first duly sworn, was examined and testified as follows:

EXAMINATION

BY MR. BERMAN:

Q. And, Doctor, like I said on the record, this is part two of your deposition. We're here to talk about your review of the Wheaton Chiropractic records and how those records affect your opinions in this case pursuant to the Court's order of 9/2/21. We have an hour.

As I said before, I don't think it's going to take an hour. But I won't go backwards and do anything that was already said in the last deposition. This is just about those Wheaton Chiropractic records. All right?

A. Okay.

Q. All right. So let me get a little bit of background about those records and how it

affects your opinions.

So, first of all, the records we're talking about relate to a chiropractor and chiropractic care, right?

A. That's correct.

Q. And in your career, have you ever been a trained chiropractor?

A. I have not.

Q. Have you ever practiced as a chiropractor?

A. I have not.

Q. Okay. In your medical practice or your medical group, do you employ any chiropractors?

A. I don't employ them, but I use them.

Q. What do you mean you use them?

A. I do referrals. And, actually, sometimes I pay for it. I have a comprehensive rehabilitation program, and as part of the comprehensive rehabilitation program, I use whatever resources are necessary, including massage, yoga, nutrition, and all those are extras in the program that I pay for as part of a global fee for the program.

Q. So are you saying that you sometimes referred your pain management patients to

chiropractors for additional care?

A. Well, that -- that's understating what I said. What I said is that as part of my program I actually contract with chiropractors to care for my patients. But in addition, which would subsume what you said, I -- I also refer to chiropractors as part of the care that I provide.

Q. Okay. In your work as an expert witness, do you hold yourself out as an expert in chiropractic care?

A. No.

Q. In this case -- and we're going to get into the details of the Wheaton Chiropractic records -- but do you have an opinion as to whether it's a violation of the chiropractic standard of care for a chiropractor to not document injuries or conditions in his office notes that are irrelevant to the chiropractic care he or she is providing?

MS. HAY: I'm sorry, could you repeat that question again? You broke up a little bit.

THE REPORTER: Steve, can you repeat it? I was having a little trouble.

BY MR. BERMAN:

Q. Do you have an opinion as to whether it is a violation of the chiropractic standard of care for a chiropractor to not document injuries or conditions in his office notes that are irrelevant to the chiropractic care he or she is providing?

A. Well, Mr. Berman, in -- as -- as somebody who takes care of patients, whether it be a chiropractor or a physician, when someone takes a comprehensive history, that includes documentation of all problems that exist.

If in that history things are provided and that practitioner, once again whether it be a chiropractor or a physician, leaves -- leaves it out, it would be below the standard of care.

Q. So you do have an opinion?

A. I do.

Q. Okay. Here, in this case, the chiropractor over at Wheaton Chiropractic was treating Mr. Narsimhan for neck and wrist issues, correct?

A. And arm.

Q. What part of the arm?

A. Forearm.
Q. Forearm. Okay. So here the chiropractor at Wheaton Chiropractic was treating Mr. Narsimhan for neck, forearm and wrist issues, correct?
A. Correct.
Q. Do you have an opinion as to whether Mr. Narsimhan's right lower extremity injury would be relevant to the chiropractor in his care and treatment of the neck, forearm, and wrist issues?
A. Well, the way you're wording the question, the care of the -- the leg would not necessarily be relevant to what he was doing, but the knowledge of it existing would be relevant.
Q. Why?
A. Because you need to know everything that's going on in a patient when you're treating them.
Q. Okay. So, in other words, if I'm understanding you correctly, you'd agree with me at least that when a chiropractor is physically doing his treatments of the neck, forearm, and

wrist, the pain, discomfort in the right lower extremity is not relevant to those chiropractic treatments; true so far?
A. The wording makes it very difficult to answer that question. The -- I mean, I'll restate what I said, which is that when you're treating a patient it's important to know other things that are going on. And when you're treating a pain in one place, it really, truly, is relevant to know that there is pain elsewhere.
Whether it would change how he treats the neck would be -- at this -- this juncture would call for speculation on my part, which the admonitions say that I'm not supposed to speculate, so I'm not going to speculate in that regard.
But I would say that how he treats the neck wouldn't necessarily be affected by what's going on in the leg. But, nonetheless, he has to be cognizant of what's going on there.
Q. So in your opinion -- let me see if I understand the scope of that opinion.
For a chiropractor, such as this one -- this Wheaton Chiropractic Care who's treating

the neck, forearm, and wrist, if Mr. Narsimhan had a -- a bunion, and had pain in that -- a bunion in his toe, would that be relevant to the chiropractic care?
A. The bunion probably would not.
Q. Okay. Would --
A. But it still should be included if there's pain from a bunion.
Q. Okay.
A. I might make it simple for you, Mr. Berman. The -- the Wheaton Chiropractic has a form that I would be -- believe it's on PDF, Page 6, of -- of the -- of the Wheaton -- the 68-page Wheaton PDF document. And on that document, it actually asks the patient to document what -- what problems the patient has, so that would indicate that there's relevance that they want to know that.
Q. Okay.
A. And, in fact, Mr. Narsimhan did not, in any way, indicate that he had pain beyond his hands in that form that he, himself, signed.
Q. Right. And he didn't even write that he had neck pain or stiffness, did he?

A. No, he did not.
Q. Okay. So in the confidential health report that you're referring to, Mr. Narsimhan didn't write down that he had neck or -- neck pain or stiffness, right?
A. He did not.
Q. So, in your opinion, did he not have neck pain or stiffness?
A. Probably he did.
Q. So why didn't he write it down?
A. Why don't you ask him.
Q. Okay. That's what -- that's what we intend to do, Doctor, exactly. In fact, that's my point. The fact that some aspect of his pain or discomfort is not written down in that confidential page -- confidential health report, if it's not written down, it doesn't mean that he doesn't necessarily have pain.
A. It means he's not documenting it.
Q. It means he's not documenting, exactly. And why he's not documenting, we'd have to ask him, not you. Would you agree?
A. I would agree.
Q. Okay. And what you're -- I think what

you have been saying, and what I think you are going to say, is that the relevant aspect of the Wheaton Chiropractic records for you, in your opinions regarding this case, are that they are silent as to the right lower extremity, true?

A. Well, you know, again, I have to think about your wording of that. What I would say is that there are pain diagrams, so if you look, for instance, at PDF Page 10 --

Q. Uh-huh.

A. -- we have a visual examination of the patient that is then filled out by the chiropractor, which I think they call a physician, and in it we see where -- where he is documenting pain. And what we see is the -- the shoulder. We actually don't see -- necessarily see the neck, it could be the neck. We see the shoulder and we see the forearm and we see the hand.

Q. Okay.

A. And there are multiple examinations with diagrams in the chart.

Q. Sure. I'm going to show you -- let's make sure we're clear on just what we're talking about.

It's this page you're referring to. This is Page 10 of the Wheaton Chiropractic records, right?

A. Correct. Yes.

Q. Okay. And if we can zoom in on that, this is the pain diagram you're referring to, right?

A. That is correct.

Q. Okay. And it shows marks in the left inner elbow and down the foreman into the wrist of the left hand, correct?

A. Right. And thank you for blowing it up, because now I can see the neck better than I was able to see --

Q. Got it.

A. -- it on mine.

Q. And it does show Xs in the neck on the left-hand side and down into the left scapular region, right?

A. Right.

Q. Okay. And this is written by the chiropractor himself, not by Mr. Narsimhan?

A. That's correct.

Q. Okay. So the only relevant aspect of

those pain diagrams is it indicates what the chiropractor noted as to what was relevant to the chiropractor for his care and treatment in terms of complaints.

Would you agree?

A. No.

Q. No. And you've never spoken to the chiropractor, Dr. Hanus, in this case, have you?

A. I have not.

Q. Okay. Are you familiar with that -- I'm sorry, it's Dr. Hallum. I made a mistake. Correct that. It's Dr. Hallum.

Do you know Dr. Scott Hallum at all?

A. No.

Q. Do you have any knowledge -- other than looking at his -- his chart, this 68 pages, do you have any knowledge as to how Dr. Scott Hallum creates his -- his notes and what he finds relevant to him in his notes?

A. Well, I have some knowledge of it because I've read all the notes carefully.

Q. Okay. If Dr. Scott Hallum, the chiropractor from Wheaton Chiropractic, would testify that it was not relevant to him as to

whether his neck, forearm, and wrist patient had any pain in his ankle, and therefore he didn't document it, would that affect your opinions?

A. It would affect --

MS. HAY: Objection --

THE WITNESS: -- my --

MS. HAY: Excuse me, just one second, Doctor. I'll just object as an incomplete hypothetical based on testimony that hasn't been given in this case.

But you can answer, Doctor.

THE WITNESS: It -- it would -- I would question the -- how meticulous and careful he is if he's filling out a diagram and he doesn't mark everything that's there, whether it's what he's treating or not.

BY MR. BERMAN:

Q. I understand you'd question that. But how would that affect your opinions in this case?

A. Well, it would lower my opinion if he's not doing a complete job.

Q. Lower your opinion as to what?

A. As to how he documents his care.

Q. Okay. And how would that affect your opinions as to Mr. Narsimhan's right lower extremity injury?
A. I don't understand the question.
Q. Would it affect your opinion, one way or the other, whether the right lower extremity injury was causally related to the incident at Lowe's?
A. Well, they are -- they are -- in this 68-page document, there are actually two sets of notes that are done on different systems and from different periods of time. And both of them are completely consistent in the absence of any documentation of problems in the lower extremity. And -- oops. Hold on.
So the opinion that I derive from these two sets of records from different periods of time is that Mr. Narsimhan was not having pain in the lower extremity that he ever filled out, ever represented, ever discussed and ever was elicited on evaluation.
Now, when somebody treats a patient, it's an obligation to evaluate the patient and not to just to -- well, I'm only treating the

shoulder, so I'm not going to look at anything else when I'm doing a visual spinal examination as is set forth in -- on PDF Page 10. But we then go to Pages 62, 65 and 67, where there are other chart notes that, once again, do not document anything.
Now, my opinion here, very clear, Mr. Berman, is that -- and we're not going to get into my other -- my other analysis of the other records, because that's not our purpose here today.
Q. Right.
A. But what my -- my -- what I derive from this, in addition to the other opinions that I have in this case, is that this giant hiatus of time where there is an absence of him reporting or a healthcare professional documenting any problems in the left leg means to me --
MS. HAY: Excuse me, I think it was the right leg, Doctor.
THE WITNESS: It was the right leg, I'm sorry.
MR. BERMAN: It is the right, yes.
THE WITNESS: Okay, the right leg. The leg.

MR. BERMAN: Yes.
THE WITNESS: It means to me that there was not CRPS there. And, you know, you heard from me previously, where we're not going to go, about the lack of documentation until somebody, years later, then documents the CRPS. But the reality of CRPS is that you don't have two years from an injury to then all of sudden present with CRPS symptoms.
And if you were to hypothetically state that he did have CRPS at a later date, you would have to then also invoke another injury that was sustained that caused it because there's no -- and I'll say this absolutely -- there is no temporal correlation between the incident at Lowe's and the later presentation. And the -- the gap is clearly demonstrated in the Wheaton Chiropractic records.
MR. BERMAN: All right.
BY MR. BERMAN:
Q. In the Wheaton Chiropractor -- Chiropractic records, in part, seem to indicate that he was treating there with a chiropractor for carpal tunnel syndrome in the wrists; is

that right?
A. I don't know. That was -- that was not the entirety.
Q. That's part of it?
A. That's part of it.
Q. In part, okay. So you agree with me, right?
A. In part, yes.
Q. Okay. Good. My question for you is, you're an expert in CRPS, not carpal tunnel syndrome, right?
A. Well, if it were between me and a hand surgeon about carpal tunnel syndrome, I would defer to a -- to a hand surgeon. Nonetheless, I diagnose and treat carpal tunnel syndrome in this practice. I am not -- I do not possess the same degree of expertise with regard to carpal tunnel syndrome that I do to CRPS, but I have a modicum of expertise there as well.
Q. Okay. Does carpal tunnel syndrome cause neuropathic symptoms?
A. Yes.
Q. Does CRPS cause neuropathic symptoms?
A. Yes.

Q. When you are acting as an examining -- an expert examining doctor, you customarily take a history from people you examine, right?
A. That's correct.
Q. In the history portion of your examination, you can ask the person you're examining for information that the treating doctors may not have asked or may not have documented in their office notes, right?
A. I think it's beyond the scope of this deposition.
Q. No, it's not.
A. Ms. Hay?
MS. HAY: Can you repeat that question, please, Steve?
MR. BERMAN: Sure.
BY MR. BERMAN:
Q. In the history portion of your examination, you can ask the person you're examining for information that the treating doctors may not have asked or may not have documented in their office notes?
MS. HAY: Yeah, I'll object, Steve. I'm not sure how that relates to the Wheaton Chiropractic

records and this portion of the supplemental deposition, or part two.
MR. BERMAN: The whole point is there's a lack of information in the Wheaton Chiropractic records regarding the right lower extremity. I think there --
MS. HAY: Well, can -- can you ask that question in the nature of the Wheaton Chiropractic records, and restate it?
MR. BERMAN: Well, this is foundational to my next couple of questions that relate specifically to Wheaton Chiropractic. This is foundational.
MS. HAY: Well, how -- how is -- how is his taking of a history -- well, can you -- repeat the original question one more time, please, I'm sorry, so that I can hear it one more time.
BY MR. BERMAN:
Q. In the history portion of your exam you can ask the person you're examining for information that the treating doctors may not have asked or may not have documented in their office notes?
MS. HAY: I do think that that is not related to the Wheaton Chiropractic records, number one. And number two, you're asking about his personal

practices, which is not appropriate. I think you can rephrase that question.
MR. BERMAN: He's an examining doctor in this case.
MS. HAY: Pardon?
MR. BERMAN: He's an examining doctor in this case. He examined Mr. Narsimhan.
MS. HAY: I understand that. So that's -- asking him about his examination of Mr. Narsimhan does not relate to the Wheaton Chiropractic records as a basis for his opinions.
MR. BERMAN: Are you going to refuse to allow him to answer that question, because I'm going to move to ask him -- attempt to have him answer that question.
MS. HAY: Doctor, if you think you can answer that question in the context of what -- what you've reviewed to prepare for this deposition, go ahead.
THE WITNESS: Sorry, I'm not the lawyer. I already objected saying that I didn't see it was -- see this as relevant to my review of the records that I prepared for today.
MR. BERMAN: So you're refusing to answer the

question as phrased?
THE WITNESS: Maybe -- why don't you try to ask it in a different way that will make me feel more comfortable about answering.
MS. HAY: And will make me feel comfortable.
MR. BERMAN: So, for the record, you're refusing to answer the question as phrased?
THE WITNESS: As phrased, yes. But I'm not refusing, necessarily, to answer the question; I'm refusing to answer it as phrased.
MS. HAY: And, Steve, I'm going to ask you to rephrase that question in the context of how that specifically relates to the Wheaton Chiropractic records and in accord with the Court order saying that this is what this deposition is limited to.
BY MR. BERMAN:
Q. In this case there's a lack of information in the Wheaton Chiropractic records documenting any, one way or the other, any information about the right lower extremity; would you agree?
A. There is no information with regard to the -- to the lower extremities.
Q. And so the Wheaton -- so when you say

no information, what -- what I'm asking you, to be clear, is in the Wheaton Chiropractic records, there's no information about the right lower extremity one way or the other, injured, not injured, pain, not pain, it doesn't even mention it?

A. Well, actually, that's not necessarily true, because the absence of positive information is negative information. And the failure to document is basically a statement that there is nothing going on there.

Now, you don't have to go along stating a bunch of negative things. But if things are positive, they need to be stated; and if they're not, it's assumed they're negative.

Q. So I'm just wondering how -- how extensive that -- that opinion is. If a patient, such as Mr. Narsimhan, would go to a cardiologist to get tested, but doesn't mention anything about his right lower extremity pain or symptoms, does that mean that he's not having that pain on that day that he sees his cardiologist?

MS. HAY: I'm going to object as an incomplete hypothetical based on facts not in evidence as

well as form.

But I think you've answered that.

MR. BERMAN: And there's no objection such as that in the rule of evidence.

But go ahead and answer it. Please, answer.

THE WITNESS: If you're going to a cardiologist with a serious heart problem, you're probably not going to be talking about what's going on in your leg because that's a life-threatening situation.

When you're going to a chiropractor and it's all about pain, and they're doing a spinal examination and they have a history form that specifically requests information regarding all body parts that could be having pain and you leave it out, that's a negative.

BY MR. BERMAN:

Q. It sounds to me, Doctor, when you say the absence of positive information is the negative information, what you're saying is that, because in the Wheaton Chiropractic records the right lower extremity isn't mentioned one way or the other, that therefore means that

during those office visits and during that time frame that Mr. Narsimhan was seeing a chiropractor, he was not having any pain in his right lower extremity.

Is that what you're saying?

A. There is no documented pain in his lower extremity.

Q. Okay.

A. And that would be relevant to a chiropractor.

Q. Well, I didn't ask you about whether it was documented or not.

MR. BERMAN: Can you repeat that last question I had, please, for an answer to that question.

THE REPORTER: Sure.

(Record read as requested.)

MR. BERMAN: I just want an answer to that question.

THE WITNESS: Can you, Margie, repeat the last sentence of the question, not the -- you don't have to repeat the entire question or my answer.

(Record read as requested.)

THE WITNESS: I'm saying he never expressed it.

BY MR. BERMAN:

Q. I know. And I'm asking you if you're making an assumption that not only did Mr. Narsimhan not express that he had right lower extremity pain during his chiropractic care at Wheaton Chiropractic, but is it your opinion that he did not have any right lower extremity pain during that September to December time frame he was being treated by the chiropractor over at Wheaton Chiropractic?

A. I would -- I -- I -- yes, that would be my opinion.

Q. Okay. Isn't that then making an assumption about a fact that's actually not in the record?

A. Well, one -- one does an evaluation at the beginning and then takes a history. What is or is not in that history is what is the legal document. And I'm not the lawyer, but my understanding of medical records is that if it's not there -- if it's not documented, it's not

there.
Q. And that kind of goes back to my question before. If something is not documented and you do an examination of a person, like Mr. Narsimhan, you can, through your personal history, get more information than what's written in the medical charts and records, right, by asking the patient or asking the person you're examining?
A. That's correct.
Q. Okay. As an expert examining doctor, if there's a lack of information in the records, you don't just make an assumption as to what information would have been in the records had that treating doctor chosen to write it down, right?
A. No, because that's the whole purpose -- you know, I believe in this case I was not allowed to submit any forms to Mr. Narsimhan. I'm not sure if this case was one of those where -- no forms will be filled out today.
But reality in this situation is that when he presented to the chiropractic office, they gave him a form that he is supposed to

document what's going on. And granted, he did leave out the neck for whatever reason. But what I can tell you, Mr. Berman, emphatically, is that when somebody has CRPS pain, it's something that's at the forefront of their mind and they're not going to leave it out.
And so my opinion about him not having CRPS pain there in his leg is based on the fact that this is something he would put down on the form. And he can -- I don't know if he's going to say he forgot because he was going about his neck. But when people have CRPS, it's usually the most important issue that they have. And it -- it's something that I -- I couldn't comprehend why it would be left out if it's bothering him.
Q. Okay. So you're making a judgment about Mr. Narsimhan saying that he would have put down right lower extremity pain on the forms, and he would have complained about that to the chiropractor when he's going to see the chiropractor for his neck and forearm and wrists. And since he didn't do that, that means that Mr. Narsimhan wasn't having any pain in his

right lower extremity, right?
A. No. He wasn't having enough to be putting it down there. And, you know, again, we're only looking at a microcosm of -- of this case. And there are a lot -- there's a lot of other relevant information that was discussed in the first part of this deposition that we're not going to discuss today that contributes to my opinions, such as the videos of him.
Q. Doctor, I'm simply asking you about the Wheaton Chiropractic time frame.
A. Right.
Q. And the time you saw him.
A. Okay. And -- but you're being punctilious in the way you're asking the questions to try to elicit an opinion from me that he didn't have pain in his leg because he didn't write it down, and I am not affirming that opinion that you're trying to elicit.
Q. Okay. I thought you were, actually. I thought you were saying that specifically. In fact, I thought you were saying that it is your opinion that during the time Mr. Narsimhan was going to Wheaton Chiropractic for chiropractor

care for his neck, forearms, and wrists that he was, in fact, not having right lower extremity pain or discomfort because it's simply not written down or wasn't reported to the chiropractor.
MS. HAY: I'll just object to as mischaracterizing his prior testimony.
But you can go ahead and answer, Doctor.
THE WITNESS: Well, I think there may -- what you heard and what you inferred and what I implied I think are two very different things. And so maybe I should just be more emphatic and ask Margie to strike or to -- for the sake of clarity, I'll just say and -- that we should disregard what was previously stated, because it could seem somewhat convoluted, and state more clearly this is my opinion, disregarding the other part.
Is that the fact that Mr. Narsimhan did not document any pain in his leg on the forms and in the history -- oral history that he provided is an indication to me that his leg was not troubling him at that time.

I hope that's clearer than what I said before.

MR. BERMAN: Okay.

BY MR. BERMAN:

Q. So when you say not troubling him, I just want to follow up when you say that. You say an indication that his right leg was not troubling him, are you making sort of a characterization to the extent he might have been having some discomfort, but not to the extent it was necessary to report it?

I'm trying to follow up and understand what you mean when you say not troubling him.

A. Okay. That he was not having significant pain enough to write it down --

Q. Okay.

A. -- or report it.

Q. Well, that does help answer my prior questions. And so I guess I just want to make sure we're clear, and just to follow up again one more time.

Is -- what you're saying is during the time that Mr. Narsimhan was seeing the chiropractor over at Wheaton Chiropractic, he may have had

some pain or discomfort in his right lower extremity, but just not significant enough at that time to be reportable -- or for him to report it. Is that what you're saying?

A. I think you're restating, kind of massaging what I said a little bit, that there was no pain of significant consequence to be able to -- for him to feel it was important enough to report it.

Q. Yeah. But what that means is he may have had some pain or discomfort, but just not to the level of significance enough to report it. Am I right? Is that accurate?

A. Well, you know, if we -- I will accept that with the following caveat that CRPS pain would not fit into that category.

Q. But would you actually answer my question though?

A. Well, that is your --

Q. No.

A. The answer. I think I am answering your question.

Q. I didn't ask about CRPS.

A. I'm saying that if it -- that, perhaps,

if I accept your hypothesis that there was some pain, but not enough to report, my opinion is that if that was true, and it could possibly be true, it would only be true if it wasn't the pain of CRPS because that pain would not be characterized by the way that you are characterizing it.

Q. Okay. I think you've already explained it. I'm not going to get into this. But you've already explained that CRPS pain can be treated medically with drugs, like Lyrica or Neurontin or gabapentin, right?

A. Well, we're getting outside the scope.

MS. HAY: I'll just object -- hold on just one second, Doctor. Let me just object to going beyond the Wheaton Chiropractic records.

BY MR. BERMAN:

Q. Doctor, during the time that Mr. Narsimhan was going to the Wheaton Chiropractic for chiropractic care, he was on drugs, such as Lyrica and gabapentin, which could treat or diminish the symptoms of CRPS, correct?

A. Well, what I have to say is that in preparation for this deposition today, I did not review the other records and cannot tell you

from memory from several months ago about which medications he was taking at that time and which ones he was not.

Q. Okay. Hypothetically, assuming that during the time that Mr. Narsimhan was treating with Wheaton Chiropractic over at -- with Dr. Scott Hallum, the chiropractor, in September through December of 2016, if Mr. Narsimhan was being treated medically with Lyrica and then gabapentin/Neurontin, those would be the type of medications that would help diminish the pain from CRPS, right?

A. You're asking me if either pregabalin or gabapentin can diminish and usually not eliminate the pain of CRPS, and the answer is those medications can do that.

Q. Okay. When you examined Mr. Narsimhan, you were not aware of the Wheaton Chiropractic records, true?

A. I -- I had not reviewed them.

Q. Okay. Had you reviewed the Wheaton Chiropractic records prior to examining Mr. Narsimhan, would you have asked him about that care and would you have asked him about how

his right lower extremity was feeling during that period of time when he was seeing the chiropractor over at Wheaton Chiropractic from September to December of 2016?

A. Well, I think -- I mean, again, we're not going to my exam and my history as part of this evaluation. But to the best of my recollection, I asked him a temporal history, and he didn't indicate that there was a period of hiatus of pain, whether it be from Wheaton Chiropractic or anything else.

But I don't -- I have not reviewed that -- that -- my -- my examination and my history to be able to say anything sworn under oath emphatically.

Q. I'm just asking you if had you reviewed the Wheaton Chiropractic records, would that have caused you, as an examining doctor, to ask Mr. Narsimhan some questions about those records or about that time frame that he was seeing the chiropractor in September to December of 2016 during your examination.

A. It's not my practice to do a comprehensive review of the records before I see a patient in an independent medical examination so that I can

have an unbiassed opinion not affected by the prior records, but to hear what the patient has to say, and then to do an analysis of the medical records vis-a-vis my exam and history to come up with my final opinions.

Q. Okay. If you make the assumption that I think -- and I think you are, that during the time that Mr. Narsimhan was seeing the chiropractor over at Wheaton Chiropractic he was not having significant enough right lower extremity pain or symptoms to report those, how does that affect your opinion as to whether Mr. Narsimhan had an injury from the Lowe's incident that was -- an injury that was causally -- strike that.

Let me restate it. If you hold the opinion that during this time frame that Mr. Narsimhan was being treated at Wheaton Chiropractic for his neck and forearm -- forearms and wrist during September to December of 2016, that Mr. Narsimhan was having some complaints of pain in his right lower extremity, but just not significant enough to report to his chiropractor, how does that affect your opinion as to whether Mr. Narsimhan had an

injury -- an injury of some sort causally related to the Lowe's incident of 6/25/16?

A. Well, the scope of my testimony in general in this case will not be whether he sustained any kind of injury at that time. It would be whether the incident at that time caused the subsequent development of CRPS.

And regardless of what my opinion is with regard to whether he sustained an injury at that time, it is my opinion that he did not develop CRPS as a result of that in -- of that incident and that the Wheaton Chiropractic records support that opinion.

Q. Okay. And then just to follow up on the reason that the Wheaton Chiropractic records support that opinion is because -- and correct me if I'm wrong, if I misheard you earlier -- but what you're saying is, if Mr. Narsimhan was complaining of right lower extremity pain caused by the condition CRPS while he was seeing his chiropractor in September through December of 2016, the pain in his right lower extremity would have been more so severe and significant that he, more likely than not, would have reported

that to his chiropractor; is that right?

A. I -- I endorse that summary.

Q. Okay. During his chiropractic care on October 25, 2016, Mr. Narsimhan had an office visit with his neurologist, Dr. Farbman, who was treating Mr. Narsimhan for leg pain -- right leg pain anterior, and he was treating him with Neurontin. And when I say treating him, I mean he changed his medications from Lyrica to Neurontin.

To be -- to be fair and to be clear, you're not arguing in this case -- or you don't have the opinion in this case that on October 25, 2016, Mr. Narsimhan was not having significant right leg pain -- right leg anterior pain when he saw Dr. Farbman on October 25, 2016; is that right?

A. Once again, we're talking about records that are not the subject of this deposition today, and I didn't review them in preparation for today, and can't make a comment in that regard.

Q. Well, Mr. Narsimhan saw his chiropractor on October 26, 2016, the day after he saw

Dr. Farbman, and there's no comment whatsoever about Mr. Narsimhan's right leg injury, his right leg anterior pain or discomfort or what he was -- what medications he was on at that time, agreed?

MS. HAY: Let's -- let's --

THE WITNESS: Yeah.

MS. HAY: -- let's take a look at the record, Doctor.

THE WITNESS: Well, no, it's on Page 35 of the record, if I remember.

MR. BERMAN: Page 35.

THE WITNESS: What's that?

MR. BERMAN: Yes, Page 35.

THE WITNESS: Right. On Page 35, we -- we have the examination of October 26, 2016, and --

MR. BERMAN: I have it up on the screen.

THE WITNESS: Oh, I have it on my screen too.

MR. BERMAN: Okay.

THE WITNESS: So it's a two-page thing. You're not showing -- there's a second page -- but there is a second page.

And -- well, if the question is is he discussing anything related to the leg, clearly

he is not.

MR. BERMAN: Okay.

THE WITNESS: And he has an assessment of a bunch of things. But, I mean, if I go to my own -- my own practice and somebody has, for instance, diabetes -- which isn't also documented here but -- I would be including the diabetes as one of the diagnoses here. And maybe doctor -- the chiropractor wasn't aware of the diabetes. But leg pain is something that is in his wheelhouse.

MR. BERMAN: Uh-huh.

THE WITNESS: Where he -- there are codes for leg pain whether you're treating it or not. And there's -- and that's something that's within the scope of what he does is pain throughout the body.

Now, the other thing, Mr. Berman, that's very important is that should somebody have CRPS, you certainly would want to know about that in doing any kind of treatment.

MR. BERMAN: Okay.

THE WITNESS: Yeah. And I --

MR. BERMAN: I understand what you're saying.

THE WITNESS: What's that?

MR. BERMAN: I understand what you're saying.

BY MR. BERMAN:

Q. But if we look at this October 26, 2016, record from the doctor -- from the chiropractor, it says that he's being treated for left-sided lower neck pain which radiates down left arm to left wrist with intermittent numbness and tingling, right?

A. Correct.

Q. It doesn't mention -- this chiropractor visit note of October 26, 2016, doesn't mention anything about the fact that the very day before, on October 25th, this same patient, Mr. Narsimhan, was at his neurologist's office complaining of right lower extremity pain and receiving a medication to treat that right lower extremity anterior pain, correct?

A. Yeah. Without having recently reviewed Dr. Farbman's records, if what you're saying is true, then that would be correct.

Q. Okay. And that would lend itself -- so understanding that would lend itself to the understanding that these chiropractic notes are

not complete when it comes to reporting the history of the right lower extremity pain and discomfort that Mr. Narsimhan was experiencing; is that correct?

A. Well --

MS. HAY: I'm going to object -- hold on just one second. I'm just going to object to the form of that question with regard to you're now asking him to comment on whether these records are, quote, complete.

But you can go ahead and answer, Doctor.

THE WITNESS: The -- the bottom line that -- that I -- I have here is that from the onset of the presentation to the chiropractor, the chiropractor is working from documents where Mr. Narsimhan did not -- did not represent that he was having any leg pain, and that the early examinations where there's a diagram that shows where pain is, did not include anything from the leg.

And so as we're moving on in time to -- what is it, yeah, that was October 26, 2016, clearly at that time the chiropractor is not

focusing on the leg or probably asking any questions about the leg. But we have three prior pain diagrams, if I remember right, on 9/21/16, 10/11/16 and -- yeah. And I think -- well, Page 10 -- let's just go to Page 10.
BY MR. BERMAN:
Q. I think you've already talked about Page 10. We've already looked at it.
A. Yeah. But -- but I'm putting things in context here.
Q. There's also a pain diagram on Page 14 and 15.
A. Right.
Q. In case you're looking for it.
A. Yeah. That's what I'm looking for. And on those pain diagrams, there's nothing related to the leg.
Q. Right. So going back to October 26th for a moment.
A. Right.
Q. That's page -- oops.
A. Pardon me?
Q. That's Page 35.
A. Yeah.

because now he's working up in the arm and the neck.
But the reality is he has no reason to be thinking about the leg anymore, because when he did his evaluation, and when Mr. Narsimhan wrote and signed the document and did not include anything about a leg, and what I said previously is that when you have CRPS pain in the leg, you don't -- you do not neglect to put it down on the form. If it's bothering you, you put it down on the form because it becomes the main event.
The CRPS pain is the main event. And clearly it's not the main event here, whether it be on intake or even later. Because it becomes relevant to the chiropractor, and anybody treating him, if there's CRPS and you're talking about doing things that potentially could exacerbate his CRPS or cause a spread to it elsewhere in the body, you better know that something else is going on.
And, you know, it's not clear to me why this plaintiff, with all the other information that I found to have discrepancies, it's not

Q. Now, assuming that Mr. Narsimhan is still having the same pain in his right lower extremity that he was talking to his neurologist about just a day before, but he went into his chiropractor on October 26th and didn't mention the right lower extremity pain at all, doesn't that affect your opinion as to whether Mr. Narsimhan was having pain -- or significant pain in his right lower extremity during the time he was seeing his chiropractor?
A. Well, you know, what you're saying is on October 25th he went to see Dr. Farbman, he had pain, and Dr. -- the chiropractor is proceeding with his treatment and not paying attention to the pain because -- you see, the way treatment goes, whether it is chiropractic or medical -- let's say medical pain treatment --
Q. Uh-huh.
A. -- is that you gather your basic information and then you go about treating what -- what you treat in the context of the comprehensive evaluation that you do at the beginning. And so it would not be abnormal at this time for him not to be discussing the leg,

clear to me why, if he were having bad pain, he would not be disclosing it to the chiropractor, and then it subsequently would not be getting documented. I think we're kind of going in circles.
Q. Right.
A. Right.
Q. Again, I just want to make sure, because you keep saying it's bad pain. You're characterizing it in a certain way.
When a person feels in terms of pain that's bad or significant, that's really up to the person, right?
A. Pain is subjective, if that's what you're asking.
Q. Subjective. Okay. So depending on -- in terms of what Mr. Narsimhan chose to complain of or document to his chiropractor, that's kind of -- we have to ask him why he chose to do that. You can't make that assumption or speculation, right?
MS. HAY: I'll just object to asked and answered.
You can answer again, Doctor.

THE WITNESS: Well, I think we already agreed that you wish to ask him why he concealed that information, or certainly didn't offer it up.

CRPS is -- it's an important problem, and we wouldn't be here in this lit -- as somebody who, you know, specializes in CRPS, and without soliciting legal work gets these kind of cases, the kind of demands that -- and that's not really relevant to me -- but the kind of demands that are made that bring me into a case all the way into Chicago, and have, you know, three lawyers and a court reporter here on the phone are not insignificant kinds of problems that aren't -- or there isn't demand for a lot of damages.

And if it's so insignificant that he's not mentioning it at any time in, I don't know how many -- I have exams that start documents on 6, 10, 14, 19, 18, 21, 23, 27, 29, 31, 33, 35, 37, 39, 41, 43, 45, 47, 49, 51, 53, 55, 57, 59, 60, 62, 65, 67. Those are all individual notes where it never got brought up by this guy now who wants to sue for a lot of money, I assume. I don't know how much he wants to sue for.

But if he's saying that the CRPS is so substantial that he needs big damages, and he doesn't even report it in that plethora of examinations that I just listed, then something is inconsistent.

BY MR. BERMAN:

Q. Earlier in your prior deposition you were critical of Dr. Buvanendran for cutting and pasting some of his records from one day to the next.

In the Wheaton Chiropractic records, did you notice that there are certain records that seem to be cut and pasted from one office visit to the next? You did not?

A. I did notice that. And, actually, when you were asking me to characterize the care, at one point I was thinking about bringing it up. But I think you asked me another question, so I didn't get the opportunity to share that with you.

But the answer is I clearly did because I'm critical of that kind of practice.

Q. Right. And you're critical of Dr. -- the chiropractor, Dr. Hallum's note-taking procedure because he cuts and pastes elements of his office visits from one day to another.

Are you willing to reply on his office visit notes to indicate that Mr. Narsimhan is not having a significant right lower extremity issue despite the fact that it's not -- the right lower extremity is not mentioned one way or the other, right?

A. Okay. Well, if I were a lawyer, I would object for that being argumentative. But what I will tell you is that the initial notes were not cut and pasted, and they -- there was a complete lack of any kind of documentation or even an allusion to anything related to the pain, including pain diagrams that were not cut and pasted because they're each unique.

Q. Okay. So it's the initial -- it's the chiropractor's initial --

A. You realize that --

Q. -- that are not important.

A. -- where we -- even though we started late, we're running over the hour.

Q. Actually, we're not. We started at 10:42 and it's 11:38.

MS. HAY: We've got four minutes. And I will just have like three questions at the end, Steve.

MR. BERMAN: Okay.

BY MR. BERMAN:

Q. So it's the initial -- the chiropractor's initial -- first couple of records that are most significant to you, right?

A. May -- well, then we go -- they're not cut and pasted when you start again on Page -- PDF Page 62. Those -- that's a new system, and there's no cut and pasting into that system. And, once again, there's nothing on Page 62, 65 or 67 which represents visits on 7/29, 8/30 and 10/31/17 that ever make an allusion, once again, to the leg problem.

Q. Okay. I'm going to ask you to assume certain things for this next couple of questions.

Assuming for this question that Mr. Narsimhan was experiencing right lower extremity anterior pain that continued and persisted throughout the chiropractic treatment, but was never addressed or noted by the chiropractor, would that affect any of your

opinions in this case regarding causation?
MS. HAY: Objection, asked and answered.
You can answer again, Doctor.
THE WITNESS: I -- with all -- you know, I don't know if you want to say they're hypothetical or your assumptions, but with all those assumptions, I would continue to have the same opinion I've been having, which is subsumed and asked and answered.
MR. BERMAN: Doctor --
THE WITNESS: Well, let me finish answering the question.
MR. BERMAN: Go ahead.
THE WITNESS: My opinion would be, if the pain were significant enough, it would have been communicated. And that the reason I am excluding causation of CRPS from that incident is because at no time did Mr. Narsimhan, who subsequently complained that I abused him or whatever during the exam that you witnessed, where I clearly went out of my way not to do anything that would be painful to him and deferred much of the parts of my examination to avoid harming him. And then he goes to a visit

a month later and doesn't report it, but then two months later he does, we have a big inconsistency.
And that's the same kind of inconsistency that we could potentially see where he's going to Dr. Farbman on the 25th, and then on the 26th not saying anything about the pain. Or when he comes to his first three visits with the chiropractor, one where he fills out a history where he doesn't put it in and three documented pain diagrams where there's nothing in the pain diagram that represents anything related to his pain and they're unique.
So I still exclude causation, and that's the bottom line.
BY MR. BERMAN:
Q. Doctor, assuming for purposes of this question, that there was right lower extremity anterior pain that started after the impact with a narrow rod at Lowe's, and persistent since that time through September -- September to December 2016 time frame in which Mr. Narsimhan was seeing a chiropractor, and it continues to this day, would that make it more probably true

than not, that the right lower extremity pain is causally related to the incident at Lowe's, even if the diagnosis, CRPS, is not accurate?
A. Well, once again, here I didn't review the records. I didn't review the video of the impact, and I'm trying to remember if the piece of metal actually struck him anteriorly or dorsally.
Q. Well, it was anterior.
A. Okay. So I still don't make a casual relationship. But more importantly, I see so many inconsistencies in the chart in this gentleman who is obese, diabetic, with diabetes out of control for significant periods of time. And my working diagnosis is not CRPS when I evaluated him, but instead it was diabetic neuropathic pain, which is a different kettle of fish than CRPS, and is treated with the medications that Dr. Farbman had prescribed him.
Now, what I can further say on that is that the -- the use of either gabapentin or pregabalin is FDA approved for the treatment of diabetic peripheral neuropathy pain, and it's not approved for the use in complex regional

pain syndrome.
Q. I'm just going to object to move to strike any portion of that answer relating to diabetic neuropathy. We've covered that opinion extensively in your prior deposition, and I didn't ask about diabetic neuropathy. So with that, I'll pass.
MS. HAY: Just a couple of questions, Doctor.
EXAMINATION
BY MS. HAY:
Q. In that -- in the Wheaton Chiropractic records, in the initial history forms that Mr. Narsimhan was asked to fill out, was it your understanding from a review of those forms that he was asked to identify any symptoms he either had or had -- either he had at the point in time he went to Wheaton Chiropractic or had prior to that time?
A. Well, I think, Ms. Hay, that the answer to that is on the form. And I don't know if you didn't see it or if Mr. Berman didn't see it, but it says: We want to know all about the facts about your health before we accept your case. Please check the appropriate box for any

of the following symptoms which you have or have had previously.

So Wheaton Chiropractic is putting it there straight out in front. Mr. Narsimhan, before you sign this form, tell us everything about yourself so that we know what we need to treat you. And clearly he did not do that.

Now, he may have -- you know, he left out the neck, but he may have seen that as part of a conglomeration relating to the arm. But in terms of the leg, clearly, if there was a problem, Wheaton Chiropractic wanted to know it. He read this.

He is an educated man, and that's not part of this deposition. But we know that he has beyond a college education. I believe he has a master's degree, so he's educated. He can read. He signs something and leaves out a very important thing. And my -- what my -- my opinion in that regard is that he just wasn't reporting it because it wasn't significant to him.

Q. Doctor, at some point in time, were the -- did -- did the chiropractor -- one of the

questions.

Dr. Hallum appears to be the chiropractor that saw him at Wheaton Chiropractic, correct?

A. Yes.

Q. Did it appear to you through the 20 plus, 25 visits that Dr. Hallum was the same chiropractor that was treating him for all of those visits?

A. I got to remember. I just got to look at the ones near the end.

Yeah, he's the one at the end, and he was the -- oops, hold on. And he was the one at the beginning. Yes. So I -- I -- I had to check to see. But, yes, he -- he -- he -- he's the chiropractor that saw him during those two intervals of time.

Q. Okay. And the two intervals of time, Doctor, that was a period from September 2016 to December 2016. Then further care from I believe it was July of 2017 till end of October, early November of 2017, correct?

A. Yeah, it was July 29th, 2017, through October 31st, 2017.

Q. And was it your understanding from review of the records that when he came back in 2017 that Mr. Narsimhan and some documents in the Wheaton Chiropractic records again reaffirmed that he had some type of an additional problem with his neck and arms and wrists, and there was no mention of any leg pain?

A. Yeah. I just have to go back. Just -- I don't want to be -- I don't want to say anything under oath that I don't know for sure.

Q. I'm specifically looking at Page 18, Doctor?

A. 18?

Q. Page 18.

A. Oh, the ouch form.

Q. Yes.

A. And that is -- I'm sorry, yeah, the ouch form was from 7/29 of '17, when he resumed care. And so, once again, Ms. Hay, I would point out to you that this is a form that was filled out by Mr. Narsimhan. I believe it said: If you have experienced -- because he puts his name, this is his handwriting. Okay. And did you receive any other care for this injury.

But then it says: If you've experienced a sudden change in your physical condition, we would like to know about it because we want your treatment to be the best possible provided in your current state. Your complete recounting of any discomfort you have felt and may -- and any accidents or injuries you have recently, even if experienced no apparent reaction, will help us to help you. And there's nothing that he puts down, Mr. Narsimhan puts down related to leg pain.

And I believe this diagram is his diagram. This is not the diagram of the -- of the chiropractor. This isn't the one filled out by the chiropractor. This is filled out by Mr. Narsimhan. And, once again, they're asking for everything, and he's showing his arm, but he's not showing his leg.

Q. Okay. Doctor, were there some assessments that you saw in the Wheaton Chiropractic records where there was an assessment of the patient's gait or ambulation by the chiropractor?

A. I don't recall that.

Q. Okay. With regard to some of the

claims that, apparently, Mr. Narsimhan had as to what -- what activities of daily living he could or couldn't do or that were aggravated by this neck or shoulder, forearm, wrist condition, were some of those claims of activities he couldn't do similar to some of the claims that he's made in this case that relate to his lower extremity?
A. Ms. Hay, I'm just a little confused by the question.
Q. Sure. Let me ask this. In terms of the Wheaton Chiropractic records, did you see that Mr. Narsimhan had complained that there were certain things he couldn't do because of his upper extremity injuries?
A. Yes.
MR. BERMAN: Objection, foundation.
BY MS. HAY:
Q. Did that include, as to what's noted in the records, problems with playing the guitar?
MR. BERMAN: Objection, foundation, relevance.
THE WITNESS: I -- I -- I believe I saw that, but I don't remember for sure.
MS. HAY: Okay.

BY MS. HAY:
Q. Did you see complaints with regard to problems sleeping?
MR. BERMAN: Objection --
THE WITNESS: Yes.
MR. BERMAN: -- foundation, relevance.
BY MS. HAY:
Q. Did you see complaints with regard to him sitting too long or doing computer work?
A. Yes.
MR. BERMAN: Foundation.
BY MS. HAY:
Q. Did you see some indications of some problems with -- with rotational issues or turning his body?
MR. BERMAN: Objection, leading.
THE WITNESS: You know, it might be useful to just refer to these -- the documents where they are so that it would refresh my memory. Because this one line of questioning, I -- somehow I'm missing some of the answers in my head.
MS. HAY: That's, okay, Doctor. I don't want to spend too much time on it. I think you've answered the questions that I have.

And with that, Steve, I'm done.
MR. BERMAN: Okay. Just -- just one follow-up specifically, on that one form that you -- the health report we talked about.
THE WITNESS: The one called the ouch report?
MR. BERMAN: No. The case history confidential health report, Page 6 of the record.
THE WITNESS: Okay. Yes.
FURTHER EXAMINATION
BY MR. BERMAN:
Q. And I know you -- you quoted from that directly. Right here, it says -- and I have it -- actually have it up on the screen.
You quoted from it when you were testifying.
A. Yeah, I did.
Q. It says: Please check the appropriate box for any of the following symptoms which you now have or have had previously; O for occasional, F for frequent.
Things like headache, there's no box checked for headache.
Is it your opinion that Mr. Narsimhan

was saying that he never had a headache in his life?
A. That is what he's saying.
Q. Okay.
A. Whether it's true or not, I can't tell you. But he is not saying that he's had a headache.
Q. Here it says: Neck pain or stiffness. Nothing is checked at all.
Is it your opinion that Mr. Narsimhan was saying he didn't have any neck pain or stiffness ever?
A. I think -- I think in answering this haze question, I was saying that he likely neglected that because he was focusing on his hands. But I -- you know, you'd have to ask him on that one.
Q. So now you're -- what I'm hearing you say is that you're interpreting why he didn't check the box for neck pain or stiffness.
A. Okay. I'll withdraw and say you'll have to ask him.
Q. Okay. He also didn't write down that he was having any pain in his arms or elbows --

I'm trying to highlight it here -- right?
A. Correct.
Q. And the part of the arm is the forearm, right?
A. Yes.
Q. And he was being treated for, in part, forearms, right?
A. Correct.
Q. Are you trying to say that -- is it your opinion that since Mr. Narsimhan failed to write that he was having occasional or frequent pain in his arms that he, in fact, wasn't having any pain in his forearms?
A. I not saying that. I would say you have to ask him why he left that out.
Q. Okay. And wouldn't that be true, though, for all these things as to why he left it out, you'd have to ask Mr. Narsimhan why he left it out?
A. The answer to that would be a qualified yes. And a qualified yes is that the pain of CRPS is not the kind of pain that you leave off a form like this.
Q. I know. But that's your -- that's your

say that there are things Mr. Narsimhan left out, but he may be having those problems. Why he left it out, you'd have to ask him.
But on other things, like his legs or feet, he left out information, but you now know why he left it out, because it wasn't significant to him, right?
MS. HAY: I'm just going to object to form, and mischaracterizing his testimony. He's already explained it.
But go ahead and explain it again, Doctor.
THE WITNESS: Well, I'm not -- basically, you know, I think I -- you asked me to state it emphatically and unequivocally without it being unclear after that whole convoluted discussion previously.
Basically, I think it's a one-sentence explanation that I have, or opinion, as my expert opinion, that patients with severe CRPS -- with CRPS pain, it's front and center for them, and it's something that they -- it's front and center for them, and it's something they're going to include on something like this if it's

quali -- qualified judgment, that's because that's how you feel, but that's not necessarily how Mr. Narsimhan feels, right?
A. Well, you can say that --
MS. HAY: I'm going to -- hold on just a minute, Doctor.
I mean, Steve, objection to form. He's an expert in the case who's giving an opinion. That's different than what, you know -- the question is putting the two together.
I think the doctor has clearly testified about this before as to what his opinion is about CRPS and the type of pain, but has said that with regard to these specific forms, you need to go back and ask the patient why he didn't fill it out. So that's my objection.
MR. BERMAN: Yeah. But -- I understand. That's the problem. That's what I'm trying to follow up on.
MS. HAY: Well, I think you've asked him about it a number of times, and he's told you.
MR. BERMAN: Let me just ask the question.
BY MR. BERMAN:
Q. In one part of this health report you

there, because it -- it -- what I said is it's above all other pain. CRPS pain is above all other pain.
BY MR. BERMAN:
Q. But that really doesn't answer the question I'm trying to ask you.
I'm trying to ask you, on the one hand, you are using the confidential health report and saying, well, Mr. Narsimhan left certain things out such as his neck and his arms and hands -- I'm sorry, not hands, elbows and arms.
But in -- as to why he left that out, well, we don't know. We'd have to ask him. He might have been having that problem, but we have to ask him.
But as for his right lower extremity, you're not allowing him -- you're not allowing it to say -- well, why he left that off for his right lower extremity, we'd have to ask him why.
You just decided. Doesn't that seem unfair to this person, Mr. Narsimhan?
MS. HAY: I'll just object to form and unfair.
Doctor, if you want to answer again, go

ahead and give him your answer again.
THE WITNESS: I mean, I'm basically saying the same thing over and over again.
The pain of CRPS is such that you don't leave it out. And that's my medical expert opinion. I deal with these kind of patients all the time. And I think it's perfectly fair to him to ask him why, if he had bad CRPS pain in his leg or if he can say, well, that really wasn't so bad, then your legal case is a different situation.
But if he's saying that it wasn't so bad, and that's why I left it out, then so be it. And if it's severe and he left it out, you have to ask him why he left it out.
But the question is really why did he leave it out? CRPS pain is not something you leave out. And that's my opinion, and it's not going to change even if you ask me four more times.
MR. BERMAN: All right. No further questions.
MS. HAY: Okay. Thanks much.
Doctor, do you want to reserve

signature or waive it? I can't remember --
THE WITNESS: No, I never waive it.
MS. HAY: Okay. So we'll reserve signature, and if a copy is being ordered --
MR. BERMAN: I'll order it.
MS. HAY: -- we'll take a copy. Okay. Thanks, everyone.
THE WITNESS: Thank you.
MR. BERMAN: All right. Thank you for your time today. Appreciate it.
MS. HAY: Thanks.
(Proceedings concluded at 11:58 a.m.)

IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF ILLINOIS
EASTERN DIVISION
KRISHNA NARSIMHAN,)
)
Plaintiff,)
-vs-) No. 1:19-cv-012556
LOWE'S HOME CENTERS, LLC,)
Defendant.)

I, JOSHUA PRAGER, M.D., M.S., being first duly sworn, on oath say that I am the deponent in the aforesaid deposition taken on the 7th day of October, 2021; that I have read the foregoing transcript of my deposition and affix my signature to same.

_____
JOSHUA PRAGER, M.D., M.S.

Subscribed and sworn to
before me this day
of , 2021

Notary Public

STATE OF ILLINOIS)
) SS:
COUNTY OF C O O K)
I, MARGARET A. RITACCO, a notary public within and for the County of Cook and State of Illinois, do hereby certify that heretofore, to-wit, October 7, 2021, personally appeared before me, via videoconference, JOSHUA PRAGER, M.D., M.S., in a cause now pending and in the United States District Court for the Northern District of Illinois, Eastern Division, wherein KRISHNA NARSIMHAN is the Plaintiff, and LOWE'S HOME CENTERS, LLC, is the Defendant.
I further certify that the said JOSHUA PRAGER, M.D., M.S., was first duly sworn to testify the truth, the whole truth and nothing but the truth in the cause aforesaid; that the testimony then given by said witness was reported stenographically by me in the presence of the said witness, and afterwards reduced to typewriting by Computer-Aided Transcription, and the foregoing is a true and correct transcript of the testimony so given by said witness as aforesaid.

I further certify that the signature to the foregoing deposition was reserved by counsel for the respective parties.

I further certify that the taking of this deposition was pursuant to notice and that there were present at the deposition the attorneys hereinbefore mentioned.

I further certify that I am not counsel for nor in any way related to the parties to this suit, nor am I in any way interested in the outcome thereof.

IN TESTIMONY WHEREOF: I have hereunto set my hand and affixed my notarial seal this 18th day of October 2021.

Margaret A. Ritacco

NOTARY PUBLIC, COOK COUNTY, ILLINOIS

LIC. NO. 084-002796

McCorkle Litigation Services, Inc.
200 N. LaSalle Street, Suite 770
Chicago, Illinois 60601-1014

October 18, 2021
HEPLER BROOM LLC
MS. LINDA HAY
30 North LaSalle Street, Suite 2900
Chicago, Illinois· 60602

IN RE: NARSIMHAN vs.
LOWE'S HOME CENTERS, LLC.
COURT NUMBER: 19-cv-01255
DATE TAKEN: October 7, 2021
DEPONENT: JOSHUA PRAGER, M.D., M.S.

Dear Ms. Hay:

Enclosed is the deposition transcript for the aforementioned deponent in the above-entitled cause. Also enclosed are additional signature pages, if applicable, and errata sheets.
Per your agreement to secure signature, please submit the transcript to the deponent for review and signature. All changes or corrections must be made on the errata sheets, not on the transcript itself. All errata sheets should be signed and all signature pages need to be signed and notarized.
After the deponent has completed the above, please return all signature pages and errata sheets to me at the above address, and I will handle distribution to the respective parties.

If you have any questions, please call me at the phone number below.
Sincerely,
Cindy Alicea
Signature Department

MARGARET A. RITACCO
Court Reporter
(312)263-0052

cc: ALL COUNSEL ORDERING THE TRANSCRIPT

UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF ILLINOIS
EASTERN DIVISION

KRISHNA NARSIMHAN,)
)
Plaintiff,)
)
vs.) No. 1:19-CV-01255
)
LOWE'S HOME CENTERS, LLC,)
)
Defendant.)

DEPOSITION OF WILLIAM SCOTT HALLUMS, D.C., produced, sworn and examined on NOVEMBER 11, 2021, between the hours of nine o'clock in the forenoon and five o'clock in the afternoon of that day, at the offices of Performance Chiropractic, 4 West Drive, Chesterfield, Missouri, 63017, before Jeanne M. Pedrotty, a Certified Court Reporter (MO) and Certified Shorthand Reporter (IL), in a certain cause now pending in the United States District Court, Northern District of Illinois, Eastern Division, between KRISHNA NARSIMHAN, Plaintiff, vs. LOWE'S HOME CENTERS, LLC, Defendant; on behalf of the Defendant.

Job No. CS4879572

EXHIBIT C

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INDEX OF EXHIBITS

(The exhibits were retained by the court reporter and forwarded to the attorney along with their transcript.)

APPEARANCES

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IT IS HEREBY STIPULATED AND AGREED by and between counsel for the Plaintiff and counsel for the Defendant that this deposition may be taken in shorthand by Jeanne M. Pedrotty, CCR/CSR, a Certified Court Reporter and Certified Shorthand Reporter, and afterwards transcribed into typewriting; and the signature of the witness is expressly waived.

* * * * *

WILLIAM SCOTT HALLUMS, D.C.,

of lawful age, produced, sworn and examined on behalf of the DEFENDANT, deposes and says:

(Starting time of the deposition: 12:01)

EXAMINATION

QUESTIONS BY MS. FOWLER:

Q. Can you please state your name for the record?

A. William Scott Hallums.

Q. And you are a chiropractor?

A. Correct.

Q. I have handed you what's been marked as Exhibit A, and I'll represent that is the Plaintiff's Rule 26A rebuttal witness disclosure. Do you see that?

A. Yes, ma'am.

Q. Have you had an opportunity to review this

document?

A. I have.

Q. Okay. And when was the first time that the plaintiff's attorney reached out to you?

A. Date specific?

Q. Yes.

A. I'm going to say it was probably the middle to end of October; probably more middle of October.

Q. Of this year?

A. Yes.

Q. Okay. So the first time you have ever spoken to anyone about this lawsuit would have been in October of 2021?

A. Correct.

Q. Okay.

A. And if it's not, it would be the end of September. It's somewhere in that time. This fall.

Q. Sure. And were you provided -- were you provided any other documents besides your medical records for Mr. Narsimhan?

A. No.

Q. No deposition transcripts or anything of that sort?

A. Yes. I was provided the deposition of a doctor. I think it was Josh Prager.

Q. Okay.
A. I'm not sure of his name, it was in regards -- I think he was an expert in the complex regional pain syndrome.
Q. Is that your file?
A. This is my file.
Q. Do you mind if I take a look at it? Thank you. And as I understand this file is the complete file for Krishna Narsimhan; is that correct?
A. Correct.
Q. Within this file we have the patient information and I'm seeing the medical records.
A. Yes. I think it's the initial treatment visit. Everything else was in EHR, electronic health record.
Q. Okay. So this is your hard file, and then we have Rule 26 witness disclosures, and then we have -- this is a printout from the National Institute of Neurological Disorders and Stroke pertaining to complex regional pain syndrome?
A. Yes.
Q. Who printed this off?
A. Me.
Q. And when did you print this off?
A. I believe it was two days ago.

Q. What was the purpose of doing that?
A. I was -- based on what I was told this is a condition that the -- I'm assuming the Plaintiff -- Mr. Krishna is being treated for, or was diagnosed with I should say. Not treated for, diagnosed with.
Q. Let's sort of set the table here. If you treated -- the last date of treatment I have for you with Mr. Narsimhan is 2017, does that sound about right?
A. Yes, ma'am.
Q. And nobody contacted you at any point until October 2021 pertaining to an incident that occurred at Lowe's; is that right?
A. I believe US Legal Support contacted me in March of 2020 or April of 2020 requesting records.
Q. Okay.
A. I did not know what it was for. All they did was request records. And I looked back, and they said there was possible depositions that may need to be taken. I sent in a W9, or my secretary sent in a W9 to US -- I'm assuming US legal support. And that was the last I heard of it until this fall.
Q. Okay. And then this fall was the first time that an attorney actually reached out to you; is that right?

A. That's correct.
Q. Was that Mr. Berman?
A. Mr. Berman is the only attorney I spoke with, yes.
Q. And what did he tell you?
A. He told me he had a patient that was under my care in the year of 2016, and he indicated that has ongoing lawsuit -- an ongoing case with Lowe's regarding an injury that he suffered. I believe it was to his right leg or right foot. And that my name got brought up because of I was treating Krishna at the time he was suffering this injury or at the time that he had this injury going on. And that my name was brought up because of my treatment and then also in regards to my documentation.
Q. Okay. And what specifically did he tell you about the records or your documentation?
A. What specifically did he tell me about my records or documentation -- he just informed me that based on -- I guess it was a deposition -- I guess I'm assuming. I'm assuming with doctor, I guess, Prager -- am I pronouncing his name right? That there was some question in regards to my documentation that did not denote anything regarding Mr. Krishna's right leg.

Q. And what else did he tell you about that?
A. He told me how the injury occurred, that Mr. Krishna was in Lowe's and I believe he was checking out, a metal rod fell through, I'm assuming the shopping cart, hit Mr. Krishna in the foot or ankle, and that Mr. Krishna suffered some pain, discomfort and so forth, and that was the extent of that.
Q. Okay. And did he say anything about the lawsuit?
A. He indicated that there was an ongoing case between Mr. Krishna and Lowe's.
Q. Okay. And did he ask you for -- to help him or Mr. Narsimhan with respect to this lawsuit?
A. He said that I would potentially be obtained as an -- in a deposition to go through my notes regarding the case.
Q. Okay. Did he go through what he wanted you to cover with respect to your notes?
A. We went through the notes in regards to what my notes stated, and that was just basically it.
Q. Okay. And did he educate you on what complex regional pain syndrome is at all?
A. I have knowledge of it.
MR. BERMAN: I want to place an objection

to that question; foundation and the form to "were you educated".
Q. (By Ms. Fowler) Go ahead.
A. Based on my background, I have somewhat of some knowledge to it. It was generally called causalgia when I was going through school. And I think they changed it to complex regional pain syndrome. I have a general idea what it was. I did print off some material as well just to make sure.
Q. You were no stranger to the concept of what complex regional pain syndrome was back in 2016; is that right?
A. Yes. I mean we learned about it -- briefly learned about it in school.
Q. Okay. That's something that chiropractors do cover in their training; is that true?
A. In their training, yes.
Q. So I'm also looking through this file. Did we cover everything Mr. Berman told you and what you all discussed?
A. Uh-huh.
Q. All right.
A. I will step back. I don't know if I stated that right. We learned about causalgia, but it's nothing we learned about in a treatment regimen or in

regards to treating it.
Q. But you learned how to identify it; true?
A. Yes.
Q. Got it. Okay. And then we have some other medical records in this file. Dr. Prager's deposition is not in the hard file. Where is that kept?
A. This is on a pdf on my laptop or iPad.
Q. So what I'm looking at, which, Doctor, if it's okay with you, I'd like to mark your file as an Exhibit, Exhibit B?
A. That's fine.
MR. BERMAN: No objection to marking the document.
Q. (By Ms. Fowler) We'll make copies of it and have that, but we won't take your original file.
A. Okay.
Q. And then the electronic file, as I understand it, consists of Dr. Prager's deposition and then the ongoing treatment records that you have with Mr. Narsimhan; correct?
A. Correct. And it also contains Exhibit A, but I have three --
MR. BERMAN: Objection to the form of the question; ongoing treatment record. I think his treatment records ended in 2017.

MS. FOWLER: Well, Steve, just to clarify what we're looking at here in the room is the initial record in the hard copy and ongoing treatment records would be treatment records from after the first date through 2017. That's what we're referring to.
MR. BERMAN: Those would be subpoenaed records that were provided to me.
Q. (By Ms. Fowler) Okay. So let's talk about the Exhibit A. Are these your words or is this Mr. Berman's words when we look at the subject matter on which the witness is expected to present evidence?
A. Me and Mr. Berman had a phone conversation. It probably lasted, I don't know, 20 or 25 minutes, and I spoke to Mr. Berman on the phone and this is what we talked about. And they printed up this report right here.
Q. Okay. All right. So let's go through -- what I'd like to talk to you about just generally speaking is what chiropractors do, if that's all right.
A. Yeah.
Q. So I understand -- so I did a little bit of research before coming here today because I didn't want to sound stupid talking to you.
A. Yeah.

Q. But I understand -- I went to the Cleveland Clinic and I just typed in chiropractor. And Cleveland Clinic seems like a reputable place. And I printed off what they have on chiropractic adjustment and all of that good stuff. But as I was going through this, and you can tell me if I'm wrong on this, but if you go to the third page of that, is it true to say that chiropractors can treat pain anywhere in the body?
A. Yes.
Q. And is it true to say that would include in the head, and the jaws, the shoulders, the elbows, wrists, hips, pelvis, knees, ankles?
A. Correct.
Q. Okay. And as I understand it a chiropractor would look at the whole musculoskeletal system and try to treat the root of the problem; is that accurate?
MR. BERMAN: Object to the form of the question. It's not related pertaining to this particular case. Go ahead.
Q. (By Ms. Fowler) Go ahead.
A. Okay. They can look at the musculoskeletal system.
Q. Okay.

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A. And treat the root of the problem.
Q. All right. So chiropractors -- would you agree chiropractors make sure not only that the joints are moving properly, but also the surrounding muscles are functioning well. That's part of the job; is that right?
A. That's correct.
Q. Okay. And now, in terms of what you do, I understand that you were working at Wheaton Chiropractics?
A. That was my clinic, yes.
Q. That was yours?
A. Yes.
Q. Now you are working for Performance?
A. That is it; correct.
Q. Would you agree that Wheaton Chiropractic and Performance have the same philosophy on how they treat their patients?
A. Correct.
Q. And I understand that Wheaton Chiropractic did have a web site when it was in existence?
A. Correct.
Q. So any patient could go on that web site and see what sort of things that you do for your patients?

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A. Correct.
Q. And they can look at the philosophy of that?
A. Correct.
Q. So I went on -- since that's no longer existence it's not on the web site, but I just want to go through this. I'm going to have this marked as Exhibit C. This is screen shots of Performance's current, we believe, site. If you can just -- is that true?
A. That is correct.
Q. And what I'm interested in is if we look at, you know, it says welcome to Performance Chiropractic, and the last sentence up here it says, "We strive for our patients to truly come in as strangers and remain as friends."
A. Correct.
Q. That would be true for Wheaton Chiropractic as well?
A. Yes.
Q. That's something that you would have advertised to potential or perspective patients; is that true?
MR. BERMAN: Object to the relevance of that.

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Q. (By Ms. Fowler) Go ahead.
A. I did not advertise this as Wheaton, but, yes, I would feel that it is, you know, an adequate statement.
Q. Okay. It also states, "Our doctors are experienced in techniques to promote healing in all areas of the body." Do you see that?
A. Second paragraph.
MR. BERMAN: Object to the relevance.
THE WITNESS: Oh, yeah. Promote healing in all areas of the body. Okay.
Q. (By Ms. Fowler) That would be something accurate that you would promote to your patients back at Wheaton; right?
A. Yes.
Q. Okay. And that goes with the philosophy of we treat the body as a whole; correct?
MR. BERMAN: Objection to foundation and relevance to this particular witness. Go ahead.
THE WITNESS: We treat the body -- in regards to that, I would not say that we treat the body as a whole on every patient, but I'm saying, yes, we treat the body as a whole. We treat the head. We can treat the knee, ankle, the spine, or whatever the case may be.

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Q. (By Ms. Fowler) And that makes sense to me. And then I went on and I saw your bio.
A. Uh-huh.
Q. I'm going to mark your bio as Exhibit D. Is that a true and accurate copy of your biography as relates to your work as a chiropractor?
A. Just 20 pounds heavier, but yes.
Q. Okay. What intrigued me is that it states that, "Dr. Hallums enjoys treating patients who suffer from common structural injuries, sports-related injuries, headaches, and postural imbalances."
A. Correct.
Q. That's something that you did, you do here, but you also did back in 2016 at Wheaton?
A. That's correct.
Q. And it says he also practice functional medicine?
A. Uh-huh.
Q. That's a new concept for me, I didn't know what that was, so I did look that up. It kind of gives us some context here. It looks at the body symptoms through various lab tests and blood work to find the root cause of many illnesses.
A. Correct.
Q. I wanted to dive a little bit deeper into

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the functional medicine concept. So the Internet will set you free. I printed off the role of chiropractic care in functional medicine.

A. Okay.

Q. What I want to confirm and make sure my understanding of what it is a functional medicine is, something that you do for your patients. It means -- if we go to patients center treatment?

A. Uh-huh.

Q. It says that it means doctors focus on the whole person rather than a disease or disorder; is that right?

A. Yes. We look -- we dive down into a deeper level as opposed to more superficial, like just musculoskeletal. We look at gut, gut biome, things of that nature.

MR. BERMAN: For the record, I want to place an objection on the record. This is for the court reporter. I place an objection to the foundation of these questions, to the relevance and materiality as they don't relate to the patient at issue, and it's beyond the scope of the disclosure for purposes of this deposition. Beyond that, go ahead.

MS. FOWLER: Okay. And it states -- you can have an ongoing objection, Steve. I'm fine with

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that. We can have a rolling objection if you like.

MR. BERMAN: I'll have an ongoing objection to these questions because, again, otherwise I have to object to each particular question. That's fine. Thank you.

Q. (By Ms. Fowler) Okay. And as a functional medicine chiropractor, am I saying that correctly -- is that the way you say it?

A. Uh-huh.

Q. Instead of finding the quickest way to eradicate symptoms, you -- the functional medicine chiropractor searches for the root of the patient's problems; is that right?

A. Correct.

Q. And you recognize each patient's individuality rather than taking a one size fits all approach; is that correct?

A. Correct.

Q. I'm also looking at mind, body, and spirit, as part of functional medicine, chiropractic?

A. Uh-huh.

Q. You probe deeper than just finding out what's going on physically with your patients; is that true?

A. That is correct. Can I say something real

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quick?

Q. Go ahead.

A. I want to make a note that when I saw Mr. Krishna I did not have a functional medicine degree.

Q. Okay.

A. I just recently got that.

Q. But did you still have that philosophy and mindset that you don't want to just sort of put a blindfold on and feel the spine. You want to have a full, deep level understanding of who your patients were, and what their issues were regardless?

A. Correct.

MR. BERMAN: I object to the form of the question as well.

Q. (By Ms. Fowler) Go ahead.

A. Okay. Yes. When a patient entered the office I would address a thorough assessment of what they presented with.

Q. So it would be fair to say even though you may not perhaps have had the certificate, degree or whatever is required for functional medicine chiropractic, the mindset that you had and how you treated your patients was the same; is that true?

A. The same as -- are we referencing a specific statement or just as the body as a whole?

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Q. Let me ask that question better. Even if you weren't licensed as a functional medicine chiropractor back in 2016, the philosophy that we just talked about and philosophy behind functional medicine chiropractic, you did incorporate that in your treatment of your patients; is that true?

A. Yes.

Q. Okay. And I think I see that in the records that we see, and we'll get into that, but I just wanted to make sure this was sort of the philosophy that you had back in 2016 so that we can firm this up, but you aim to maximize your overall vitality rather than simply treating the disease, that was true back in 2016 on how you care for your patients?

A. Uh-huh.

Q. That's yes?

A. Yes.

Q. Okay. So one of the things that I found interesting also is that taking an integrated approach, and I'm look right here. It's understand how does a chiropractor fit in?

A. Okay.

Q. Chiropractors can treat complex but common illness such as chronic fatigue syndrome and

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fibromyalgia?
A. Uh-huh.
Q. Is that something that you would also have been doing back in 2016 if someone were complaining about those symptoms?
A. Yes. I have had patients with chronic fatigue syndrome and fibromyalgia.
Q. So it's not just my neck hurts, my spine hurts, you're looking at entire body as a whole to see what's going on with your life, how are you living your life, and how are you doing in your life; is that fair?
A. Yes.
MR. BERMAN: I'll place an objection again, same standing objection, but also specifically that's it doesn't relate to this patient.
Q. (By Ms. Fowler) Go ahead.
A. I would assess activity of daily living of things of that to incorporate that into their treatment.
Q. Okay. All right. And I would imagine that if that is your philosophy you're going to spend some time when you first meet a new patient to kind of understand who they are; is that right?
A. Yes. Usually we block off 30 minutes for

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new patients.
Q. And that would have been true back in 2016; is that right?
A. That is correct.
Q. So if we go to your initial exam when you first see the plaintiff -- I will mark that as Exhibit E. This is the case history. Here you go, it's easier to do it that way. And this case history is a form that I would imagine you submit to all your patients; is that true?
A. That's correct.
Q. And did you for the plaintiff as well in this case; true?
A. That is correct.
Q. And to sort of set the scene a little bit, you may or may not know this, but the Lowe's incident happened in April of 2016. Did you know that?
A. I did not.
MR. BERMAN: It happened in June by the way. Objection, you're misstating evidence in the case.
Q. (By Ms. Fowler) Sorry. Let me ask that question again. Thank you, Steve. The Lowe's incident happened in June 2016?
A. Okay.

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Q. And then the plaintiff came to see you for the first time is September 20 or 21, 2016; is that right?
A. Correct.
Q. Okay. And this form is a standard form, kind of -- when I saw this after I researched what the philosophy you have in treating your patients it all adds up to me. This form says we want all the facts about your health before we accept your case. Did I read that correctly?
A. Yep.
Q. And that's something that you want and you encourage your patients when they come in the door that that is the philosophy of your care; true?
A. We like to gather all information so we know what is going on with the patient.
Q. Okay. And it says please check the appropriate box for any of the following symptoms which you now have or have had previously. Did I read that correctly?
A. That's correct.
Q. So basically you're saying I don't only need to know what is going on with you right now in this moment at this time, I want to know about your track record, I want to know everything about you;

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right?
A. That's correct.
Q. And there is various categories in here, this is what sort of we talked about before, you would agree that exhibit -- what is that C -- E?
A. This is E.
Q. Exhibit E is sort of a deep dive philosophy of your practice; true?
A. I wouldn't say it's a deep dive of my practice. My practice primarily focuses on musculoskeletal conditions, but we like to know underlying conditions the patient may have.
Q. It's important so you have a full picture?
A. Yes. And in regards to treatment as well.
Q. Sure. And one of the -- I mean if we go through these, when we're talking about a deep dive, you're asking questions about whether or not the patient has had any convulsions or dizziness or fainting; right?
A. Correct.
Q. You have asked whether or not they had colon trouble or constipation or even diarrhea; correct?
Q. You have asked about hemorrhoids and liver trouble?

A. Correct.
Q. You asked things as simple as whether or not they have had a cold or earache or eye pain; right?
A. That is correct.
Q. You want to know about whether or not they have frequent urination, painful urination; true?
A. Correct.
Q. And if it's a women, not only are you asking about what their menstrual flow is like, but you're also wanting to know what the date of the last period was; true?
A. Correct.
Q. And it's not because you're going to do a gynecological exam on a woman or treat a person for, you know, eye issues, but it's so that you have a full understanding of what they have experienced with their history, and what they're currently going through?
A. That is correct.
Q. And one of the things that you have in here on this form is whether or not the patient has suffered from foot trouble; true, if you go under muscle and joint?
A. Muscle and joint, that is on there. Yes.
Q. And you ask whether or not they have any

swelling of ankles; true?
A. Swollen joints; is that where we're looking at?
Q. Yes, sir.
A. Yes. Swollen joints is on there.
Q. And specifically you asked whether they have or have ever experienced pain, numbness, or cramps in their legs or their feet; true?
A. Up there, that is on there; correct.
Q. And in your deep dive not only do you ask about all of that stuff, you also want to know when their last physical exam was, when their last dental X-ray was, et cetera; true?
A. Correct.
Q. And you also ask whether or not they have -- not only them, but also family members whether or not they have had symptoms or syndromes listed in these categories; true?
A. Correct.
Q. And this -- at the very end of this, it says after filling out this case history, your signature will attest that the information you have given is accurate and that you have read the case history questions entirely. Did I read that correctly?

A. That is correct.
Q. So not only are you telling them in the beginning of the form, hey, make sure that you respond in full, but you're also saying, hey, listen, when you sign this you're vouching that all of this is accurate information you're giving me; true?
A. Correct.
Q. And let's see how Mr. Narsimhan filled out this form. The only boxes that he checked in terms of the upper portion of this form is that he had numbness and either pain, numbness or cramps in his hands; is that true?
A. That is all that is checked on the form.
Q. He didn't tell you anything about foot trouble or pain in his legs or his feet did he?
A. No.
Q. All right. And he did tell you about the dental X-ray he had in 2016?
A. Correct.
Q. But he never mentioned anything about any treatment for his leg or his foot, did he?
A. No, not on the form.
Q. All right. And you specifically asked again -- you asked twice on this form whether or not he had any foot problems, and twice he has not checked

that box; is that true?
A. That is correct.
Q. All right. But he has told you about his diabetes?
A. He did.
Q. All right. And now, so this is just you expect your patients to be forthcoming with any issues that would be bothering them in that moment, but also at any point during their life; true?
A. Say that again.
Q. Sure. Would you expect for your patients to be forthcoming with any issues that are currently troubling them, but any big issues that are going on with their life; true?
A. Whatever is pertinent to them, yes.
Q. Even if -- once again, even if you're not treating those particular things, you still you encourage them, you tell them you have them fill out a form to tell them I want to know those things?
A. Correct.
Q. Now, you also do an independent examination; correct?
A. Correct.
Q. And this is so that you can verify whether or not there might be any issues they forgot to check

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that you're seeing something; true?
A. Correct.
Q. I'm going to hand you what's been marked as Exhibit F. And that is the physical exam or the examination report you did on September 21, 2016; is that right?
A. Yes. This is the spinal exam form.
Q. Now, when Mr. Narsimhan came to you for the first time he weighed 219 pounds and he was 5' 8"?
A. Correct.
Q. Would you categorize that as obese?
A. Correct.
Q. What does gait mean?
A. Gait is his walking pattern.
Q. All right. So if a person is walking with a limp or they are wincing in pain or show any issues with them walking, you would note either that it was irrelevant, impaired, slow, or hesitant; is that true?
A. That is correct.
Q. And when you observed him walking in your office, you noted that his gait was normal; correct?
A. Based on this exam, yes.
Q. So based upon your own physical exam of him, you noticed that there was nothing -- there was nothing wrong with his feet or anything of that sort;

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is that true?
A. Correct.
Q. And then ambulation, what is that?
A. Ambulation is how you get up, up and down from your chair, how you move from your chair to the table, so moving about.
Q. Okay. So if the person is having terrible pain in their foot or in their leg, you would expect that their ambulation might be a little bit of a hindrance; is that correct?
A. Correct.
Q. And here we see that his ambulation -- his moving around was normal?
A. Correct.
Q. And that's what you observed with your own two eyes; true?
A. Correct.
Q. And you also noticed -- you note appearance. Why is appearance important to document?
A. Their overall appearance can tie into their health, their wellness. You know if somebody is obese or somebody is disheveled, their shirt is untucked or hair is all a mess, we want to note those things as well.
Q. If I'm understanding you, it shows you that

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they may be in distress to some extent if they seem disheveled or things of that sort; am I getting it right?
A. Correct. Or there could be mental health issue stuff like that as well.
Q. Fair enough. If a person was being driven by pain, would you expect that they appear distressed and their appearance would not be good; is that fair?
A. Possible, yes.
Q. But you noticed with Mr. Narsimhan when he showed up to you the first day that his appearance was good?
A. Uh-huh.
Q. And that's a good thing?
A. Yes.
Q. Now, if we look at the posture analysis, if I understand this correctly I know that he was there to see you for his hands, his neck, I guess, his arms?
A. Uh-huh.
Q. But you're not only stopping there because, again, that's against your philosophy. Your philosophy is to look at the body and one of the things is the lumbar spine?
A. Uh-huh.
Q. Now, I see that you are doing flexion --

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you check his flexion?
A. Uh-huh.
Q. His extension, and all of that good enough?
A. Correct.
Q. So if I'm playing this out in my mind, Doctor, it seems to me that you would be sort of having him bend over, bend back sideways, maybe?
A. Yes. I am not touching him, but he is performing the acts.
Q. Okay. You are able to say are you able to bend down all the way, are you able to touch your toes?
A. Yes.
Q. And things of that sort?
A. Correct.
Q. So that, again -- once again if you thought a person was having a burning sensation in their leg and their feet, you might notice that they might have the some limited range of motion in that area; true?
MR. BERMAN: Objection; calls for speculation, form of the question also.
Q. (By Ms. Fowler) Go ahead.
A. Not in the lower back, no.
Q. Not in the lower back, but when you're doing these exercises a person might winch in pain;

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true?
A. Possibly.
MR. BERMAN: Objection; form of the question.
Q. (By Ms. Fowler) Go ahead.
A. Possibility that they could wince in pain, yes.
Q. I'm trying to play it out in my mind. If I have terrible leg pain and foot pain and you ask me to bend down and touch my toes or bend backwards, it's probably going to hurt a little bit?
MR. BERMAN: Objection; speculation, all prior objections as well.
THE WITNESS: That joint is not moving. That joint is stationary. We're looking at the lower back joint. So if you had pain in the lower back, yes, I would say it would be dependent upon if they would have ankle or foot pain.
Q. (By Ms. Fowler) Okay. So the bottom line is this; that your exam is not just limited to checking to see what his situation is with his neck and his hands, but you're looking at, again, the entire spine, the body as a whole; true?
MR. BERMAN: Objection to "body as a whole."

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Q. (By Ms. Fowler) Go ahead.
A. In this case we're looking at the spine, primarily neck and upper back.
Q. You also check reflexes?
A. We did.
Q. And reflexes from the leg?
A. We do.
Q. And so how does that work when you're checking, are you hitting the hammer to the knee?
A. Yes.
Q. So you're actually using a device and hitting to make sure -- so you're actually doing things with his legs; true?
A. Yes.
Q. And I see that you did a straight leg raise?
A. Correct.
Q. So you're actually having him lay on the table and lifting under his leg to see whether or not that creates any pain?
A. I have the patient lift up their leg. He would be laying supine on his back and he would lift up his leg like this.
Q. Okay. And, again, if a person is having terrible pain in their foot and leg, at some point

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during this physical examination if they forget to tell you on the form to check the body you're probably going to see it during this 30-minutes interaction; true?
MR. BERMAN: Objection; form, foundation, calls for speculation.
THE WITNESS: Possibly. I did not do any orthopedic exams during this examine that emphasized anything on the foot or the ankle. These were on the spine and straight leg raise was for any type of sciatica.
Q. (By Ms. Fowler) I understand what the purpose is. But to be clear, you're putting -- I mean his moving his legs around?
A. He is moving his legs, yes.
Q. He is not moving them just a little bit. He is moving them in such a way it's obvious that you can see sitting across the room from him?
A. Correct.
Q. What's going on with him?
A. Correct.
Q. There is portion that says notes, do you see that?
A. Yes.
Q. So even if you're not treating him for his

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leg pain or foot pain, if you notice that he was wincing in terrible pain, you could write it in the notes section that he has pain?
A. Correct.
Q. And I don't see anything in the notes saying anything of that sort?
A. Correct.
Q. What does this say? I can't read your notes?
A. HP is forward head posture and in hyperkyphosis of thoracic spine, which is kind of rounding of the shoulder. You have got almost like a hump in your lower back -- excuse me -- in your upper back. It's postural things.
Q. Okay. You didn't do that examination report just once, you did it -- in fact, actually, it's the second page of that. I just put those all together. You did it again on October 11, 2016, we can see, we can see your work product here.
A. Correct.
Q. And once again, you went through the same thing, you checked his gait and gait was normal; true?
A. Correct.
Q. You checked his moving around and that was normal?

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A. Correct.
Q. He had a good appearance?
A. Correct.
Q. You were still doing the flexion, reflex check and all of that; true?
A. Correct.
Q. And at no point during your physical examine of him did you ever note that he had or was wincing in pain or showed any signs of distress as it would relate to his leg or his foot?
A. Correct.
Q. All right. And if we go to November 26, 2016, again it's same thing, you're again looking for things, you're looking to see if he is walking normally; right?
A. Correct.
Q. You're looking to see whether or not he is able to move around normally?
A. Correct.
Q. And you're looking to see whether or not he appears in distress or anything of that sort; true?
A. Correct.
Q. And you're noting everything is fine; right?
A. Nothing was noted in regards to that;

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correct?
Q. All right. And once again, you're still doing those physical things, those physical tasks, that would necessarily require him to use his leg and his feet, and you are not noting anything showing that he is in pain or distress; true?
A. There is nothing noted.
Q. Okay. And certainly, Doctor, if it was something you observed, you certainly would note that; true?
A. Correct.
Q. All right. So if we go to what I have marked as Exhibit G. I like the title of this form. It's called the ouch form. It pretty much describes itself?
A. Yes.
Q. But as I understand it, when I was looking at this form, in case a patient says oh, wait, I forgot to tell the doctor this is going on in my life or wait, I forgot to tell the doctor this is really bothering me, there is actually a form they can submit and it asks those questions and they can answer those things; true?
A. Are you referencing this form right here?
Q. The ouch form, yes.

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A. Okay. This form is for patients that have a new injury or have an exacerbation of their condition that have not been in the office over an extended period of time.
Q. Okay. And certainly, Doctor, if a patient who's been treating you -- treating with you for his neck and his hands --
A. Uh-huh.
Q. If he were to come to you and say doctor, I'm having a terrible time with my leg and foot, I don't know if that's something you do, but I need to let you know; you would want him to fill something like this out, too?
A. Correct.
Q. And I didn't see any ouch forms pertaining to his leg or his foot?
A. I never treated him for any condition in his leg or foot.
Q. And he never told you about any issue with his leg or foot; true?
A. Correct.
Q. He did tell you about the fact that he had a recurring stiffness in his forearms?
A. Uh-huh.
Q. And the other comments down here I couldn't

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read your handwriting?
A. Two weeks ago mowing the lawn.
Q. Okay. And what happened?
A. And then it says just bilateral forearm, his right forearm is greater than left, and left cervical spine.
Q. If I'm reading this correctly, back in July 29, 2017, it looks like he aggravated his wrist and his hands, neck situation when he was mowing his lawn?
A. That would be correct.
Q. And you were aware at least up until that point he was capable of mowing his lawn; true?
A. I'm assuming. I had not seen him for seven months.
MR. BERMAN: Objection to the foundation, he was in fact treating him for wrists and forearm as well as neck. So foundation, to the prior question.
Q. (By Ms. Fowler) So we'll go through your treatment records. You were seeing him through 2017 -- so 2016 through 2017?
A. Correct.
Q. And at no point did he ever tell you that he was unable to mow his lawn due to his leg or his foot; true?
A. Correct.

Q. All right. Now, if we go to -- I want to walk you through this.
A. Okay.
Q. Here are -- I'll mark this as Exhibit H. Here are your day-to-day treatment records. And it does appear that you treated him from 9-21-2016 up until 10-31-2017. Does that sound about right?
A. That sounds correct.
Q. There may have been some times off or things of that sort, but that was general time period when you saw him; true?
A. Correct.
Q. Now, interestingly -- and, again, at no point -- I know you already reviewed your records to see if he ever made any complaints about his leg or his foot?
A. Correct.
Q. And we can agree as we sit here today he never made mention of either one of those things to you?
A. Correct.
Q. But he does talk about what's going on with his life as it relates to his neck; true?
A. Correct.
Q. And he tells you, Doctor, my neck is really

sort of impaired my ability to function fully; true?
A. Correct.
Q. And what he tells you about his neck is that it's bad when he sits too long; true?
A. Correct.
Q. He tells you that prolonged sitting and working on his computer really aggravates his neck?
A. Correct.
Q. And he says that his pain from his neck worsens during sleep; true?
A. Is this in the present problem where we're reading? Is this in present problems?
Q. Worse during sleep?
A. Oh, yes.
Q. I went through every single one of these records, every single time he tells you my neck is causing me problems with sitting too long, working on my computer, sleeping, and things of that sort; true?
A. He doesn't mention that ever single time.
Q. Actually, if you go through this, he does mention it every single time.
A. That is the initial complaint.
Q. Okay.
A. What my note says is the patient indicates the condition is new. Let me go on down. This is

kind of going through.
Q. As you go through it, I'll ask a better question. Certainly if it no longer is an issue you wouldn't have it in the record?
A. Correct.
Q. So we can assume if it's in the record it's going on with him at that moment in time?
A. Correct.
Q. And if I represent to you that every single record, every visit it's the same about prolonged sitting and computer work aggravating his neck pain, and that it's worse during sleep and computer work, we can assume that that was every single time he came to see you?
A. Correct. Also that it also indicates that certain times that it does get better or stays the same or does have a flare-up and gets worse.
Q. I want to talk to you about that. We do see -- you do rate his pain?
A. Uh-huh.
Q. It's scale of one to ten?
A. Uh-huh.
Q. One being -- what's one?
A. Very minimal pain at -- zero is no pain at all; ten is most severe pain you can imagine.

Q. Okay. And he is rating his pain -- I mean he is never hitting the ten mark?
A. No.
Q. In fact, as he describes his neck pain, the thing that interferes with his computer work and sitting too long and sleeping he is kind of describing like a dull ache; right?
A. Dull ache, yes.
Q. And I see there is also issues with his wrist in there, too, but it's not one of those things where his neck is on fire or his wrists are on fire and he can barely function; is that fair?
A. That would be fair.
Q. Okay. So you understand the term masking; have you heard that term before?
A. You mean -- can you give me a definition?
Q. Yeah. Sometimes you might have a patient that may have longstanding, let's say, arthritis in their neck.
A. Uh-huh.
Q. And it hurts, but they get shot in the foot, they are not going to be thinking about their neck so much, they are going to think about the gunshot that is the immediate pain; right?
A. That's correct.

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Q. This is one of those -- I'm getting the impression how you're reporting this is that this is more of a nagging issue for him, not something that is interfering with his ability to function; is that true?

MR. BERMAN: Note my prior objection to foundation and beyond the area of expertise. Go ahead.

THE WITNESS: That would be a question -- I cannot answer that question. That would be probably something for Krishna. But it is causing him discomfort. It's causing him pain and it's affecting his activities of daily living.

Q. (By Ms. Fowler) Okay. But once again when we go through all this, nothing about his leg or his foot is ever mentioned to you; true?

A. Correct.

Q. So there is no indication to you that his leg or his foot is interfering with his ability to function; true?

A. Not based on my notes and not based on my recollection of the case.

Q. One thing I did note is if you go to the 12-20-2016 record --

A. I got it.

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Q. I'm sorry. I should have tabbed it. He talks about this was new. He said that two days ago he was playing his guitar for one and a half hours on Sunday?

A. Uh-huh.

Q. And then the pain began yesterday upon walking and increased into both of his hands; is that right?

A. That is correct.

Q. When he is talking about the pain he is talking about neck pain?

A. Correct.

Q. So if I'm reading this, I can probably put my context clues together to say he is able to play the guitar for one and a half hours; true?

A. Correct.

Q. And the only thing that really upset him was it caused him a little neck pain a day or two later; true?

MR. BERMAN: Objection to foundation; calls for speculation as to what the patient was thinking.

MS. FOWLER: Go ahead.

MR. BERMAN: In addition to my prior objections that are continuing.

Q. (By Ms. Fowler) Sure. Go ahead.

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A. And numbness and tingling into his hands and swelling of his neck.

Q. Okay. So, again, nothing about his leg or his foot is made mention by him at all?

A. Correct.

Q. With respect to any of that; true?

A. Correct.

Q. Now, if we go to the 7-29-17 record?

A. Okay.

Q. This is we're getting toward the tail end of his treatment with you, but it shows a modifying factors section. Do you see that?

A. Yes.

Q. He says that his pain -- again, we're talking about pain in his neck; right?

A. Uh-huh. Correct.

Q. Is aggravated by computer use, cooking, getting out of bed, looking over his shoulder, repetitive motions and turning; true?

A. Correct.

Q. So the neck is the source of these issues for him?

A. Correct.

Q. He never made one mention of his leg or his foot; true?

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A. Correct.

Q. All right. So, Doctor, just to wrap this up, and again going back to the start of our conversation, I want to bring it full circle. The point of the way that you treat your patients is to take a broad approach to making sure that they are getting the help that they need; true?

A. Correct.

Q. And you encourage them to list any issues. Whether you're treating them for it or not, you encourage them to raise that with you?

A. That is encouraged.

Q. And you do that not just at the very beginning on that one day, but you have an open door policy throughout your entire treatment with your patients; true?

A. Correct.

Q. And you want them to open up to you; true?

A. Yes.

Q. All right. You have never gone on record or ever given any indication to your patients, look, if it doesn't relate to your neck or your hands or your spine, I don't want to hear about it; true?

MR. BERMAN: Object to the form of the question as well as the other objections.

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Q. (By Ms. Fowler) True?
A. True.
Q. And certainly if there were life limitations, caused by pain that they are experiencing, whether or not it's neck or whether or not it's for an issue that you're not treating them for, you have encouraged them time and time again please tell me about that; true?
A. Correct.
Q. Okay. And when we look at your medical records there is no record that discussions, any burning in his leg, in the Plaintiff's leg; true?
A. True.
Q. He never made mention of any leg or foot swelling; true?
A. True.
Q. He never made mention of any shooting pain up and down his calf or his foot; true?
A. True.
Q. He never mentioned to you that he was icing and taking medication for his leg and foot every day hoping that it would go away; true?
A. True.
Q. And he never reported him walking with a limp; true?

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A. True.
Q. You never saw him walking with a limp; true?
A. True.
Q. You never reported him having to change positions due to his pain in his leg; true?
A. True.
Q. And he never made mention to you that he was unable to wear socks on his legs?
A. True.
Q. He never made mention to you that he had to wear special shoes without laces?
A. True.
Q. He never made mention to you that he was showering with his foot in a bucket because the water from the shower caused too much pain?
A. True.
Q. He never made mention to you that he was unable to swim because it hurts to flip flop his legs?
A. True.
Q. He never made mention that he couldn't run or bike because of his pain?
A. True.
Q. He never made mention that he was unable to drive his car because it hurt to press the accelerator with his foot?
A. True.
Q. And, Doctor, he made no mention to you of any hair loss, change in color, swelling, shininess, or scaliness of his foot or leg; true?
A. True.
Q. I have no further questions. Thank you.

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EXAMINATION

QUESTIONS BY MR. BERMAN:

Q. Doctor, I have some follow-up questions. So based upon all that questioning, the bottom line is that your patient, Krishna Narsimhan never talked to you about his right lower extremity at all; right?
A. That is correct.
Q. Okay. He also never told you that he was seeing -- being seen and treated by a neurologist for right lower extremity pain during the time he was seeing you, did he?
A. No.
Q. Okay. The fact that Mr. Narsimhan didn't tell you that he was seeing a neurologist for right lower extremity pain during the time he was seeing you in 2016, doesn't mean it didn't exist or that treatment didn't happen, do you agree?
A. I would agree.

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Q. Okay. The fact that Mr. Narsimhan didn't talk to you, the doctor who was treating him for neck and upper extremity issues, about his right lower extremity problem that he was seeing another doctor for doesn't mean the right lower extremity problems didn't exist. Would you agree?
A. I would agree.
Q. And as a chiropractor, you don't treat every patient's whole body; is that true?
A. That is true.
Q. As a chiropractor, sometimes patients come in, they have a particular pain that they want to be treated, whether it be the neck, arms, back, low back, upper back, or the hips or anything, the focus on that pain or that problem that the patient comes in for; right?
A. That is correct.
Q. In fact, I think you said early in today's deposition, patients when they come to see you, you do a thorough assessment of what they presented with; right?
A. That is correct.
Q. And that's from your review of your records, that's what you did with Mr. Narsimhan. He comes and presents with a neck and upper extremity

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issue and you do a thorough assessment of that; right?
A. Correct.
Q. You weren't focusing on his ankle or feet or his hips; you were focusing on what he came in and presented with; right?
A. Correct.
Q. You had asked about your general examination of gait and moving around the office, and there is nothing particularly noted as problems with that; right?
A. Correct.
Q. Okay. And you didn't notate, though, any indication that he was having pain when he turned his head or moved his head; you didn't put any notes on that even though that's what he's coming in for, neck or upper extremity; right?
MS. FOWLER: I'll object. I think he did note that, Steve. It's in his records.
THE WITNESS: I think I did, but I will -- let me -- right here. Yes. I did note that on his neck with extension he had pain and tenderness, with left lateral bending he had tenderness, with right lateral bending he had pain and tenderness.
Q. (By Mr. Berman) Perfect. That's exactly what you were focusing on during this examination;

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right?
A. Correct.
Q. So the whole point of this examination really is to focus on his neck and back and upper extremities; right?
A. It was to focus on what he presented to the office with his chief complaint, yes.
Q. Okay. Going back to the confidential health report document case history, this is a standard form you have all patients fill out; right?
A. Correct.
Q. And in this case, Mr. Narsimhan did check the box that he never had a headache in his entire life. Do you take that to mean he never had a headache in his entire life?
A. Say that one more time for me.
Q. Sure. Looking at the -- this is the document that was extensively asked about in today's deposition, so I want to ask you about it.
A. Okay.
Q. You have it in front of you. Under the general, it says -- there is one line that says headache. Do you see that?
A. Yes, I do.
Q. That box isn't checked one way or the

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other; correct?
A. It is not checked.
Q. And according to the document, the patient is supposed to check the box if he now has or has had it previously; right?
A. Correct.
Q. Okay. When a patient come in and doesn't check the box "headache", do you assume he never had a headache in his entire life?
A. I would find that hard to believe.
Q. Okay. What about under the gastrointestinal part that you were asked about during today's deposition?
A. Uh-huh.
Q. Constipation, diarrhea, difficult digestion; that's not marked --
A. Correct.
Q. -- in any way for Krishna?
A. Correct.
Q. When a patient doesn't mark those items; constipation, diarrhea, or difficult digestion, does that in any way make you believe or state to you that a patient never had that problem in their entire life?
A. I would find that hard to believe.
Q. Okay.

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A. And I think -- I hope I'm answering that correctly. Just because he did or didn't check it doesn't mean that he's never had it.
Q. Just looking at this confidential health report, there are certain things on the (inaudible) -- we'll try again. In terms of this confidential health report, there are certain items on this document that even if a patient doesn't fill out you would reasonably believe that he probably had those problems at some point in their life?
A. Correct.
Q. Okay. Including things like cold, nose bleeds, sinus infection, that kind of stuff?
A. Correct.
Q. Is that correct? But what I'm trying to get at is, there are certain line items such as nose bleeds, sinus infection, et cetera on this form -- the confidential health report -- that even if a patient doesn't mark those, you'd reasonably believe they probably had that stuff previously at some point in their life; right?
A. That is correct.
Q. And when you have a patient fill out this form, it's not significant to you that they don't fill out certain things that they have had previously in

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their life. It's just not pertinent to your care and treatment; right?
A. Correct.
Q. So in this case, if Mr. Narsimhan was feeling pain in his ankle or foot, but didn't fill it out on the form, that wouldn't have any relevance to you for your care and treatment of his neck or upper extremities; right?
MS. FOWLER: Objection; calls for speculation. Subject to that, go ahead.
THE WITNESS: I'm sorry. I kind of got lost with her objection. Can you repeat that one more time? I'm sorry.
Q. (By Mr. Berman) Sure. If at this time in September 20th or 21st of 2016, if Mr. Narsimhan was having some pain in his right ankle or foot, and didn't write it down on this confidential health report form, that wouldn't have any relevance or relationship to your care or treatment of his neck or right upper extremity, would it?
A. Not of his neck or upper extremities, no.
Q. Obviously, one of the things he was being treated for was neck and upper extremity. And you already talked about that. And on this confidential health report there is specific location under muscle

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and joint for neck pain or stiffness, and that's not even checked either; right?
A. Correct.
Q. That didn't mean that you couldn't reasonably treat this patient because you were able to speak to him and talk to him as well; right?
A. That's correct.
Q. So if this form isn't fully filled out perfectly by the patient, that doesn't mean you can't treat him properly; right?
A. That is correct.
Q. And in your experience, sometimes patients don't fully fill this out; is that fair?
A. That is fair.
Q. And don't spend the time with each and every patient to go over every single line item to ask them if they've ever had in their entire life a headache or diarrhea, et cetera, do you?
A. No.
Q. Okay. And if this form isn't filled out fully, that didn't affect or change the type of care or treatment you provided to Mr. Narsimhan for his neck and upper extremity, did it?
A. No.
Q. Okay. Doctor, I think you have been

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practicing as a chiropractor for how many years?
A. Fifteen.
Q. Okay. And you received training and you're licensed; right?
A. Correct.
Q. Okay. When you take a history of your patients even though during this deposition it's been characterized as chiropractors treat the whole body, when you take a history, do you normally take a history that's pertaining to the problems that the particular patient is having?
A. Correct.
Q. Doctor, as a trained experienced licensed practicing chiropractor, is it a violation of the chiropractor's standard of care for you to not take a comprehensive medical history that notes all pains or problems a patient of yours is having even if such pains are not relevant to your chiropractic care and are being treated by other doctors?
A. Say that one more time. Is it not the standard of care or it is standard?
Q. I'm asking you if your -- if you take -- strike that. Let me back up. When you take a history -- when you took a history of Mr. Narsimhan as well as when you take a history of your patients, is it fair

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to say that you don't take a comprehensive medical history that notes all pains or problems that a patient is having even if they are irrelevant or don't pertain to the reason the patient is seeing you?
A. I take a history of what the patient presents with.
Q. Okay. And you don't intend to take a comprehensive medical history of all pains or problems a patient is having such like the type of history a primary care doctor would take; is that agreeable? Is that true?
A. Yes. I take a history of what is noted and what is -- what the patient presents with.
Q. Okay. And is that proper -- and is that proper pursuant to the chiropractic standard of care to take the history that you take?
A. I would say yes.
Q. Okay. It's not a violation of a chiropractic standard of care to not take a whole comprehensive medical history of all systems for a particular patient; true?
A. True.
Q. Okay. And foundation for saying that is that you are trained, experienced, licensed, practicing chiropractor; right?

A. That is correct.
Q. Okay. When handing this confidential health record to patients, is it common that you would tell your patients here's a form to fill out, make sure that everything that's pertinent to your care is written on the form?
A. Correct.
Q. Okay. In terms of -- I'm just going to switch gears for a moment. In terms of the gait and ambulation, that's not a specific examination of an ankle, is it?
A. It is noting patients when they walk to the exam room and when they walk and ambulate in and out of the chair and table of the exam room.
Q. But you didn't perform an orthopedic or chiropractic examination of Mr. Narsimhan's ankle; correct?
A. That is true.
Q. And with the gait and ambulation portion of that, you're not focusing in on the ankle as opposed to the feet or the knees or hips; is that fair?
A. I am not focusing -- no. I'm not focusing on just the ankle. I'm just watching the patient walk.
Q. And if a patient has pain in the ankle and

anterior portion of the ankle, but no fracture or sprain, any -- if a patient has anterior ankle pain but no fracture or sprain or functional injury to that ankle, it's possible for the gait and ambulation to be -- appear normal; right?
A. It could be possible, yes. It varies from patient to patient. So anything is possible, yes.
Q. Okay. All right. And I just want to follow up on something we started out with; the fact that Mr. Narsimhan didn't mention his right lower extremity pain or discomfort to you just means he didn't tell you, not that it didn't exist at the time. Is that a fair statement?
A. That would be fair.
Q. As for why Mr. Narsimhan didn't mention his right lower extremity pain or discomfort that he may have been experiencing in 2016 do you, you wouldn't speculate on that, would you?
A. No.
Q. Would it be fair to say rather than you speculating as to why Mr. Narsimhan didn't mention his right lower extremity pain or discomfort to you, more appropriately we should just ask Mr. Narsimhan that question?
A. That would be for him to answer, yes.

Q. Okay. And in terms of the disclosure of yours that we filed in this case that, I think, was marked as Exhibit A --
A. A.
Q. With the disclosure that we marked as Exhibit A, all that information is accurate and you agree with all that information; right?
A. That is correct.
Q. Okay. Okay. I don't think I have any further questions.
MS. FOWLER: Doctor, at this time you can either read or waive. Do you want to read the deposition transcript and make sure she's taken everything down true and correct or do you want to waive the process and waive your signature?
THE WITNESS: Waive.
(WHEREIN, the deposition was concluded at 1:13.)

CERTIFICATE OF REPORTER
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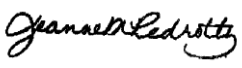

Jeanne M. Pedrotty